CHEST Topics in Practice Management

Physician Reimbursement for Critical Care Services Integrating Palliative Care for Patients Who Are Critically Ill

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Patients with advanced illness often spend time in an ICU, while nearly one-third of patients with advanced cancer who receive Medicare die in hospitals, often with failed ICU care. For most, death occurs following the withdrawal or withholding of life-sustaining treatments. The integration of palliative care is essential for high-quality critical care. Although palliative care specialists are becoming increasingly available, intensivists and other physicians are also expected to provide basic palliative care, including symptom treatment and communication about goals of care. Patients who are critically ill are often unable to make decisions about their care. In these situations, physicians must meet with family members or other surrogates to determine appropriate medical treatments. These meetings require clinical expertise to ensure that patient values are explored for medical decision making about therapeutic options, including palliative care. Meetings with families take time. Issues related to the disease process, prognosis, and treatment plan are complex, and decisions about the use or limitation of intensive care therapies have life-or-death implications. Inadequate reimbursement for physician services may be a barrier to the optimal delivery of high-quality palliative care, including effective communication. Appropriate documentation of time spent integrating palliative and critical care for patients who are critically ill can be consistent with the *Current Procedural Terminology* codes (99291 and 99292) for critical care services. The purpose of this article is to help intensivists and other providers understand the circumstances in which integration of palliative and critical care meets the definition of critical care services for billing purposes. ***CHEST 2012; 141(3):787–792***

Abbreviations: CMS = Centers for Medicare and Medicaid Services; CPT = *Current Procedural Terminology*; E/M = evaluation and management; RVU = relative value unit

In the United States, about 20% of Medicare beneficiaries with chronic illness spend time in an ICU during their final hospital admission. Nearly one-third of patients with advanced cancer who receive Medicare die in hospitals, often in ICUs.[1] For most patients who are hospitalized, death occurs following the withdrawal or withholding of life-sustaining treatment.[2,3] For these patients who are critically ill, the integration of palliative care practices and principles is essential for high-quality critical care. Although palliative care specialists are available in a growing number of hospitals,[4] intensivists and other physicians with primary or consultative responsibility for patients who are critically ill are also expected to provide basic palliative care, including symptom treatment, communication about goals of care, and transition planning.[5] Palliative care is an essential part of comprehensive critical care, with widely available tools and resources to facilitate the integration of these services.[6-10]

Patients who are critically ill often lack the capacity to make decisions regarding their own care. In these circumstances, physicians must meet with family members or other surrogates to determine appropriate medical treatments. Such meetings require

clinical expertise to ensure that patient values and beliefs are explored for informed medical decision making about therapeutic options, including palliative care.[11] Meetings with families take time, especially in the ICU, where issues related to the disease process, prognosis, and treatment plan are complex, and decisions about the use or limitation of intensive care therapies have life-or-death implications.

Inadequate reimbursement for physician services may be a barrier to the optimal delivery of high-quality palliative care, including effective communication.[12] However, appropriate documentation of time spent integrating palliative and critical care for patients who are critically ill can be consistent with the *Current Procedural Terminology* (CPT) codes (99291 and 99292) for critical care services. The purpose of this article is to help intensivists and other physicians understand the circumstances in which the integration of palliative and critical care meets the definition of critical care services for the purposes of these CPT codes. We provide examples of documentation that support the CPT critical care codes for services integrating palliative care as part of critical care for patients who are critically ill (e-Appendix 1).

The key questions we address are the following:

- What is the definition of "critical care" for the purposes of CPT codes 99291 and 99292?
- What providers can report time using critical care CPT codes?
- How does reimbursement under critical care codes compare with that under standard evaluation and management (E/M) codes?
- What is the applicability of critical care codes to the delivery of specific components of palliative care in the context of critical care services?
- What are the limitations on the use of critical care CPT codes?

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What Is the Definition of Critical Care for CPT Coding and Billing Purposes?

The codes for critical care services in CPT are 99291 and 99292.[13] These are time-based codes—that is, reimbursement is based on the time spent by a physician providing critical care, rather than directly on the level of complexity involved in evaluation and treatment. As explained in Transmittal 1548 (July 9, 2008) from the Centers for Medicare and Medicaid Services (CMS),[14] for CPT codes 99291 and 99292,

> Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or 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.

The CMS goes on to state,

> 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*.[14]

Code 99291 is used for the initial time period of service from 30 min up to 74 min. Thirty minutes is the minimum period of service for the use of this code; service for < 30 min is to be reported under E/M codes (eg, subsequent hospital care, CPT codes 99231-99233). Code 99292 is used for each "additional 30 minutes" of critical care beyond the first 74 min. Thus, if the care requires ≥ 75 min, the physician may report time using 99291 plus 99292. Time spent providing critical care encompasses the total time in a single calendar day and need not be continuous. For example, if an intensivist examines a patient who is critically ill in the morning and returns later the same day for a family meeting to establish

goals of care and make treatment decisions (including decisions to withdraw or withhold life-sustaining therapies), the time for both visits that day may be aggregated for reporting with the critical care codes. Visits on the same day by different providers in the same practice group (eg, ICU attending during the day and ICU nighttime attending) may be aggregated under the name of one of these providers, but the services reported as the initial critical care time, billed as CPT code 99291, must be performed by a single provider, according to the CMS.

Codes 99291 and 99292 may be used to report time spent providing critical care for a patient who is critically ill not only in the ICU but also in any hospital setting, including the ED or a regular medical and/or surgical inpatient unit. For example, the critical care codes might be used to report time spent providing qualifying services during a rapid response outside the ICU. Such services could include intensive palliative care (eg, emergent treatment of dyspnea with opioids and benzodiazepines) as part of a rapid critical care response on a medical and/or surgical floor for a patient with organ failure (eg, respiratory failure) or an emergent discussion with the family about whether to initiate or withhold cardiopulmonary resuscitation during a rapid response. As discussed later in this article, inclusion of the family discussion as critical care time would require, among other elements, that the physician be immediately available (ie, proximate) to the patient for the entire duration of time reported as critical care services.

What Providers Can Use Critical Care CPT Codes to Report Their Services?

Throughout the United States, the critical care codes may be used not only by critical care specialists but also by physicians in any specialty.[15] Most states also allow the use of critical care codes by advanced practice providers such as nurse practitioners, with reimbursement rates of 85% of the physician fee schedule.[16,17] Be aware that split or shared service performed by a physician and a qualified nonphysician provider of the same group practice is not reportable as a critical care service; only cumulative critical care time provided by physicians within a group is reported as such. Multiple specialists have the opportunity to use critical care codes to report time spent providing services in a given day. Physicians self-designate their specialty on their Medicare enrollment application. Providers in each distinct specialty (eg, pulmonary disease, critical care, general medicine, palliative medicine) can use critical care codes to report services meeting the criteria for these codes provided that (1) the times of the day reported by these providers do not overlap, (2) the providers are not in the same specialty, and (3) each provider selects a unique primary *International Classification of Diseases* diagnosis code.[18] For example, a pulmonary or critical care specialist might code as critical care the time spent in the treatment of dyspnea for a patient with acute respiratory failure, while a physician from a different specialty (either from the same group practice or a different group practice) could also code as critical care the time spent on the same day in a family discussion of whether to initiate or withhold mechanical ventilation based on the patient's preferences and prognosis.

How Does Reimbursement Under the Critical Care Codes Compare With That Under Standard E/M Codes?

The critical care codes support higher reimbursement than is available for services billed using standard E/M codes, such as initial inpatient service (99221 and 99223) or subsequent hospital care (99231-99233). The average 2011 Medicare reimbursement rate for 99291 is approximately $243. Each additional 30 min of critical care service is reimbursed under 99292 at approximately $122. This contrasts with the E/M rate of $105 for the highest subsequent visit code, level 3, 99233.[19]

Other time-based CPT codes are 99356 (first hour) and 99357 (each additional half hour). For prolonged, direct, face-to-face time between a physician and patient, 99356-7 can be used together with an E/M code such as 99233. The 2011 Medicare reimbursement rate for 99356 is $99. However, the use of 99356 and 99357 for prolonged, direct, face-to-face service, such as a meeting to discuss treatment options in relation to goals of care, requires the physical presence of the patient during the discussion. This is not possible for many patients in the ICU, whose consciousness or cognition is impaired by illness or sedation. By contrast, as set forth in the "Providers' Discussions with Patients and/or Families about the Plan of Care (Including the Use or Limitation of Intensive Care Therapies)" section, patient presence is not required when critical care codes 99291 and 00292 are used to report time spent by physicians in family meetings to discuss treatment options for patients lacking decision-making capacity.

Every CPT code has an assigned physician work relative value unit (RVU) established by the CMS. The critical care code 99291 is valued at 4.5, while a high-level subsequent visit code, 99233, carries a value of 1.0. The prolonged, direct, face-to-face code 99356 has a work RVU of 1.5.[20] Appropriately coding for medical care provided may also impact salaried physicians because many compensation models include a work RVU component for the determination of overall physician pay.

What Is the Applicability of the Critical Care Codes to the Integration of Specific Components of Palliative Care for Patients Who Are Critically Ill?

Key components of palliative care that are often integrated with critical care include (1) communication and decision making about treatment options in relation to the patient's prognosis and preferences (including, if appropriate, the option to limit intensive care therapies), and (2) management of distressing symptoms during critical illness. The use of the critical care codes in connection with these activities is discussed in the next sections.

Providers' Discussions With Patients and/or Families About the Plan of Care (Including the Use or Limitation of Intensive Care Therapies)

The critical care CPT codes can be used to report time spent in obtaining information from or providing information to the patient (see Table 1). Recognizing that the patient who is critically ill or injured often is incapacitated and physicians must therefore rely on a family member or other surrogate for medical decision making, the critical care codes also allow physicians to report time spent in meetings with surrogates under the following circumstances: (1) the patient lacks the capacity to participate directly in the discussion and decision making, and (2) the discussion is necessary for decision making about medical treatment. The medical record must contain clear documentation of these elements, according to the CMS. The physician should also document the treatments under discussion, which might include life-sustaining treatments that the surrogates and physicians must decide to withhold, withdraw, or continue. In addition, the participants in the meeting should be identified, and the total time spent in the meeting should be documented. For the purposes of codes 99291 and 99292, critical care does not include giving emotional support to the family or answering questions that do not directly contribute to the treatment of the patient or decision making. In documenting the family meeting, this distinction must be clearly drawn in order to support the use of the critical care codes. Caution is advised since family meetings that do not satisfy the critical care coding requirements may lead to code revision or removal, further eroding financial incentives to provide comprehensive patient- and family-centered care.

Table 1—*Requirements for Using Critical Care Codes for Family Discussions*[14]

1. Prerequisites
a. Physician is near patient room or on the unit so that the physician is immediately available to patient.
b. Patient is unable or lacks capacity to participate in medical decision making, and the family discussion is necessary for determining treatments.
c. Patient has organ failure.
2. Documentation
a. Patient is unable or lacks capacity to make medical decisions.
b. The necessity to have the discussion (i.e. patient deteriorating and need for discussion of treatment options with family).
c. Medically necessary treatment decisions for which the discussion was needed (i.e. continuing vs withdrawing mechanical ventilation, initiation of vasoactive medications, institution of artificial nutrition and hydration, do-not-resuscitate order).
d. Time spent in preparation for and during family meeting discussing treatment options and goals of care. Do not include time providing grief or bereavement support.

Time spent in physician-family discussions (in the absence or presence of the patient) about the use or limitation of cardiopulmonary resuscitation (ie, whether to attempt resuscitation or not attempt resuscitation [a do-not-resuscitate order] in the event of an arrest) is consistent with the definition of critical care according to the criteria described in this article for CPT codes 99291 and 99292 and summarized in Table 1. The same criteria would also apply to discussions in connection with medical decision making about the use or limitation of treatments, including vasoactive medications, mechanical ventilation, renal replacement therapy, artificial nutrition and hydration, automatic implanted cardiac defibrillators, or tracheostomy.

The use of the critical care codes is not limited to in-person communications, but can also include telephone discussions with family or other surrogates if the discussion contributes directly to the care and treatment of the patient and if the physician involved in the discussion is either physically present in the ICU or immediately available to the patient at the time of the call. In addition, if the patient has the capacity to participate, communication with the patient's family or other surrogate decision maker can still be reported as critical care time provided that the patient is present for the discussion and treatment options are discussed.

Many physicians find it helpful and efficient to use a documentation template for family meetings (or other services) that enumerates the elements required to support reimbursement, while leaving space to describe selected aspects of the discussion in more depth; examples of such templates are readily available and easily adapted for local use.[21] The time spent documenting services in the medical record is included in critical care time for the purposes of the CPT codes, provided the physician is immediately available to the patient as noted previously.

Management of Distressing Symptoms

All physicians, including those caring for patients who are critically ill, have a professional obligation

to address pain and other symptoms causing patient distress. The effective management of symptoms not only serves the goal of comfort but is also associated with physiologic benefits, including reduction of myocardial oxygen consumption, synchrony with mechanical ventilatory support, and improved pulmonary function. For the patient who is critically ill, symptom assessments are frequent, and management may be particularly complex and time-consuming because of hemodynamic instability, organ dysfunction, delirium, anxiety, and the concurrent use of multiple other medications. Physicians use critical care codes to report the integration of symptom and delirium management with critical care management, including continuation or weaning from intensive care therapies. There must be clear documentation that the clinical activity involves the delivery of critical care to a patient who is critically ill or injured.

Limitations on the Use of the Critical Care Codes

Physicians should be aware of limitations on the use of the critical care codes.

Medical Necessity

For the purposes of codes 99291 and 99292, critical care services must be medically necessary. Necessity is not established by the patient's mere presence in the ICU (as opposed to another hospital unit), nor is it sufficient that the patient (in the ICU or another setting) is receiving life-sustaining treatment such as mechanical ventilation or vasoactive medications. The physician's care must itself be medically necessary (and meet all aspects of the definition of critical care service according to the CMS: "The treatment and management of the patient's condition, while not necessarily emergent, shall be required, based on the threat of imminent deterioration."

Providing Care for the Patient Who Is Critically Ill vs Providing Critical Care Services

Not all care provided to a patient who is critically ill meets the definition of critical care services for the purposes of CPT codes 99291 and 99292. As explained in CMS Transmittal 1548,[14]

> Providing medical care to a critically ill patient should not be automatically deemed to be a critical care service for the sole reason that the patient is critically ill or injured. While more than one physician may provide critical care services to a patient during the critical care episode of an illness or injury each physician must be managing one or more critical illness(es) or injury(ies) in whole or in part.

Transmittal 1548[14] provides an example of a service that should *not* be reported as critical care:

> A dermatologist evaluates and treats a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist. The dermatologist should not report a service for critical care.

In contrast, a physician called emergently to treat acute dyspnea and agitation for a patient who is critically ill may meet the criteria required for reporting critical care service under CPT codes 99291 and 99292.

Physicians Practicing in Teaching Hospitals

Time spent independently by physician trainees providing critical care services may not be included in the total time reported by the attending physician under the critical care codes. A teaching physician who is present for the entire period of time that the trainees' services are delivered may report this time under the critical care codes with appropriate documentation, but cannot include time spent teaching, reviewing educational material, or performing procedures. The teaching attending's documentation must be sufficiently robust to stand alone in supporting the use of the critical care codes by that attending. It may be helpful to document treatment changes that resulted from this service (eg, addition of an opioid infusion for dyspnea, entry of a do-not-resuscitate order, or discontinuation of hourly finger sticks for blood glucose monitoring).

Counseling and Bereavement Support

For the purposes of CPT codes 99291 and 99292, critical care services reported by a physician may not include services delivered by other health-care professionals such as chaplains and social workers. Additionally, time spent by the physician providing emotional support to a grieving family member is not reportable as critical care time.

Regional Variations

Because of regional variations in the interpretation of reimbursement policies, local coding experts may provide guidance on the appropriate use of critical care codes for services integrating palliative care in the management of patients who are critically ill. Careful attention must be paid to documentation requirements supporting the use of critical care codes so as not to jeopardize their use for reimbursement of time spent providing this important patient-centered service.

Summary

Palliative care is an integral part of critical care for patients who are critically ill, regardless of prognosis,

and is delivered by intensivists and other physicians in critical care settings across the country. In the context of critical illness, the delivery of palliative care may include complex symptom management in the face of organ failure. Palliative care also includes family discussions for medical decision making about treatment options, including decisions to initiate, continue, or limit intensive care treatments. Through the use of appropriate documentation, physicians can use critical care billing codes to optimize reimbursement for fulfilling the mandate to integrate palliative care as part of comprehensive critical care for all patients who are critically ill and critically injured.

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Additional information: The e-Appendix can be found in the Online Supplement at http://chestjournal.chestpubs.org/content/141/3/787/suppl/DC1.

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