CHEST Topics in Practice Management

Critical Care in the Surgical Global Period

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This article explores the rules and regulations from Current Procedural Terminology (CPT) code set and US Medicare and Medicaid Services (Medicare) regarding multiple physicians reporting critical care services during the global period. The article takes into account the critical care definitions, regulations, documentation requirements, and services each provider can report to Medicare. A clinical scenario based on literature supporting the types of complications and care that might typically be included in the post-operative period for a patient who is surgically treated for a type A aortic dissection was analyzed. It was determined that multiple physicians may provide critical care services to a single patient during the global period. The physician who performed the primary procedure cannot report critical care separately unless documentation supporting use of modifier 25 (significant, separately identifiable services) or 24 (unrelated services) supports that critical care is unrelated to the global period. Other physicians may report critical care services separately if specific criteria are met. To report critical care services to Medicare, the patient's condition must meet the Medicare definition of critical care and the physicians should generally represent different specialties providing different aspects of care to the critically ill or injured patient as defined by Medicare. There should be no overlap in time of services provided by each physician. Each physician's documentation should clearly support medical necessity with the diagnosis demonstrating the critical nature of the patients' illness, the total time spent providing critical care, the critical care service provided, and other contributing factors.

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Abbreviations: CPT = Current Procedural Terminology; E/M = evaluation and management; NPP = nonphysician practitioner

A 68-year-old man presents with an acute type A aortic dissection requiring emergent repair. The patient suffered from preoperative shock and has a history of hypertension and previous cardiac bypass grafting surgery using an internal mammary artery graft to the left anterior descending coronary artery and a saphenous vein graft to the right coronary artery. The patient is morbidly obese with type 2 diabetes mellitus. The aortic dissection was repaired surgically using a transthoracic approach. Postoperatively, the patient experienced acute renal failure, postoperative bleeding, a cerebral infarction, and respiratory failure requiring prolonged ventilation. The patient was in critical condition with multisystem failure after the procedure. A cardiac surgeon performed the surgical procedure, provided ventilator management, and adjusted hemodynamics for the patient later that day. A hospital intensivist also provided further fluid and electrolyte management, prescribed antibiotics, and arranged for acute dialysis later that same day.[1,2]

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Critical Care Services Definitions and Regulations

The Current Procedural Terminology (CPT) and US Centers for Medicare and Medicaid Services (Medicare) definitions of critical care are very similar. Therefore, much of the language and phraseology contained within this article will be similar, if not

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identical, to these definitions.[3,4] Both CPT and Medicare define critical care as care delivered directly by a physician[3,4] for a critically ill or injured patient. A critically ill or injured patient is defined as one who has "an illness or injury impairing one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition."[4] For the purposes of critical care, vital organ systems include, but are not limited to, failure of the central nervous system, circulatory failure, shock, and failure of the renal, metabolic, and/or respiratory systems.[3,4] Both Medicare and CPT specify that critical care requires highly complex decision making in the treatment of single or multisystem vital organ failure to prevent further deterioration of the patient's condition.

Critical care is typically given in specific locations, including coronary care units, ICUs, pediatric ICUs, respiratory care units, or an emergency care facility.[3,4] Not all care given in these locations will qualify for critical care and not all critical care services are provided in these specific areas. A moment of crisis in an emergent situation does not necessarily qualify as critical care. The first criterion that should always be used to determine if a service qualifies for critical care is that the care provided meets the definition of critical care as outlined in the previous paragraph.

Critical care as defined by both CPT and Medicare may be provided over multiple days as long as the care provided continues to meet the critical care threshold and the patient's condition continues to meet the definition of critical care. The critical care codes are time based for each date and encounter. The critical care time provided to the patient does not need to be continuous, but rather is considered cumulative over the course of the day. Time that is counted toward critical care must involve time during which the physician's care is devoted solely to that of the critically ill or injured patient. Care cannot be provided to any other patients during time that is counted toward critical care. The time spent caring for the critically ill or injured patient does not have to occur at the patient's bedside. It can include time that is spent elsewhere on the floor or unit, such as the nursing station, as long as the activities are related directly to the critically ill or injured patient and the physician is immediately available to the patient. Critical care time can include activities such as reviewing test results or imaging studies, discussing the patient's care with other medical staff, or documenting critical care services in the medical record. Again, these services must be related solely to the care of the critically ill or injured patient. If the patient lacks the capacity to participate in discussions about their care, time spent on the floor or unit obtaining a medical history from the patient's family members or surrogate decision-makers, reviewing the patient's condition or prognosis, or discussing treatment options or limitations can be counted toward critical care time as long as it occurs on the unit or floor so that the physician is immediately available to the critically ill patient and the time spent and counted is focused solely on the critically ill patient. Routine daily updates or reports to family members and or surrogates are considered part of the work associated with critical care but do not specifically count toward time spent providing critical care services to the patient.[4]

Medicare has outlined specific criteria that should be included in the physician's documentation when counting family counseling and/or discussions toward critical care time. Specific documentation along these lines should include (1) documentation of the patient's condition, (2) the necessity of having the discussion, (3) the medically necessary treatment decision for which the discussion was needed, and (4) a summary in the medical record that supports the medical necessity of the discussion.[4]

Medicare regulations further clarify reporting and reimbursement for critical care services when provided by more than one physician. It is not uncommon for multiple physicians to provide critical care to a critically ill or injured patient. Providers that commonly provide critical care to a patient may involve surgeon(s) if surgery was involved, hospitalists, intensivists, and/or specialists outside the surgical specialty. For Medicare and payers that follow Medicare regulations, it will be important that certain steps are taken to ensure all individuals are reimbursed when multiple physicians participate in the care of a critically ill or injured patient. Considerations for care provided, qualifications, documentation, and reporting include the following:

- More than one physician can provide critical care at another time and be paid.
- "Only one physician may bill for critical care during any single period of time, even if more than one physician is present and providing care to a critically ill or injured patient."[4]
- Concurrent care (on a single calendar date) by more than one physician is payable by Medicare as long as certain requirements are met. Medicare's definition of concurrent care is when more than one physician renders services more extensive than evaluating and providing an opinion on an aspect of the patient's care during a period of time. The requirements that Medicare payers must consider when determining whether the concurrent care requirements are met include[5]:
  - Consideration of the patient's condition and if it warrants the services of more than one physician on an attending (rather than advisory) basis. Payers will consider the patient's diagnosis and the physician's specialties or subspecialties to

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