

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicare Reimbursement For
Critical Care Services**



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EXECUTIVE SUMMARY

PURPOSE

To examine the use of and Medicare's reimbursement for critical care codes.

BACKGROUND

Critical care is the direct delivery of medical care for a critically ill or injured patient. To be considered critical, an illness or injury must acutely impair one or more vital organ systems such that the patient's survival is jeopardized. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or emergency care unit. In 1999, Medicare spent \$353 million on critical care services.

The Health Care Financing Administration (HCFA) as well as local carriers and practitioners have voiced concerns regarding Medicare's reimbursement for critical care as it relates to:

- ▶ the provision of critical care services by provider specialties not usually associated with critical care (e.g., podiatrists),
- ▶ reimbursements for services included in the critical care service which should not be separately billed, and
- ▶ excessive amounts of services billed.

We conducted a statistical analysis of 100 percent of all critical care claims for 1998 and 1999 and of a 1 percent sample of all Medicare claims for 1999. We spoke with staff from HCFA as well as six Medicare contractors regarding critical care policy and claims processing. We only examined the issues above; we did not conduct a medical review to determine whether the billing for critical care was appropriate or necessary.

FINDINGS

Ten Physician Specialties Receive the Majority of Critical Care Payments

Internal medicine and pulmonary disease account for nearly 50 percent of critical care claims submitted, while eight other specialties account for approximately 40 percent. In 1999, nurse practitioners, physician assistants, and clinical nurse specialists received Medicare payments for critical care services totaling \$325,535 (0.09 percent of total spent on critical care).

Critical Care Services Are Not Being Unbundled

Contractors are not paying for services that should be bundled into critical care codes. Based on our analysis of 1999 data, we estimate that carriers allowed only 2,900 services for a total of \$51,800 that should have been bundled into critical care payment.

Questionable Payments for Services Have Dropped

Carrier payments continue for services billed beyond the first hour on a given day without a corresponding bill for the first hour on that day, but dropped 74 percent between 1998 and 1999.

CONCLUSION

Based on our analysis, we found that very few problems exist in the specific areas of concern outlined in this report. We believe the few problems that we identified can be efficiently corrected by HCFA requesting carriers to refine payment system edits and clarify or correct local payment policy statements. Again, we must caution that we did not conduct a medical review to determine the appropriateness or necessity of the critical care provided.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	i
INTRODUCTION	1
FINDINGS	
Ten Physician Specialities Receive the Majority of Critical Care Payments	4
Critical Care Services Are Not Being Unbundled	5
Questionable Payments for Services Have Dropped	5
CONCLUSION	7

INTRODUCTION

PURPOSE

To examine the use of and Medicare's reimbursement for critical care codes.

BACKGROUND

Critical care is the direct delivery of medical care for a critically ill or injured patient. To be considered critical, an illness or injury must acutely impair one or more vital organ systems such that the patient's survival is jeopardized. This care requires that a practitioner make highly complex decisions to treat single or multiple vital organ systems failures or to prevent further deterioration of those organ systems. Care may require extensive interpretation of multiple data sources and the application of advanced technology to manage the patient. Therefore, critical care services require frequent, personal assessment and manipulation by a practitioner to support a patient's life.

Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or emergency care unit. However, providing medical care to patients located in critical care areas does not automatically result in a patient receiving critical care services. Practitioners may provide critical care on multiple days provided that the patient's condition continues to require the level of attention described above.

Critical care is a time based code (i.e., the practitioner's total duration of time spent providing critical care services is reported, even if the time spent is not continuous). The time that a practitioner can report as critical care is the time spent engaged in work directly related to the individual patient's care whether that time was spent either at the immediate bedside or elsewhere on the floor or unit. However, a practitioner may not report time spent outside of the unit or off the floor as critical care because the practitioner is not immediately available to the patient. A practitioner may not report time spent that does not directly contribute to the treatment of the patient as critical care, even if performed in the critical care unit.

Medicare Reimbursement

The Health Care Financing Administration (HCFA) contracts with private insurance companies called carriers to process bills for services delivered by physician and non-physician practitioners.

Medicare reimburses physicians, as well as non-physician practitioners,¹ for evaluation and management services, including critical care services, provided to Medicare beneficiaries. Practitioners use Current Procedural Terminology (CPT)² code 99291 to report up to the first hour of critical care on a given date of service. A practitioner should report less than 30 minutes of critical care time using another evaluation and management code. To report each additional 30 minutes beyond the first hour of critical care, practitioners use 99292. A practitioner may also use 99292 to report the final 15-30 minutes of critical care on a given date, after the initial hour has been billed. Only one practitioner may bill for a given hour of critical care even if more than one practitioner is providing care to a critically ill patient.

Medicare does not pay for certain procedures when these procedures are provided on the same day by the same practitioner who billed for the critical care. Medicare bundles payment for these procedure codes into critical care codes 99291 and 99292. Examples of these procedures include: ventilator management, interpretation of chest x-rays and cardiac measurements, and vascular access procedures.

In 1999, Medicare reimbursed practitioners over \$353 million for critical care services, with the average rate for 99291 and 99292 services being \$193.74 and \$94.05 respectively.

Concerns

In 1999, the rate of reimbursement for critical care was reduced because of a change in the CPT definition of critical care services. Effective with the publication of CPT 2001 in January 2001, the definition has again been revised and reimbursement rate increased. Because of HCFA's ongoing efforts with these payment policy revisions, officials are interested in reviewing utilization patterns to identify unintended consequences of these program changes and correct any over or undervalued CPT codes. Additionally, several local carriers, practitioners, and HCFA staff have voiced concerns regarding Medicare's reimbursement for critical care as it relates to:

- ▶ the provision of critical care services by provider specialties not usually associated with critical care (e.g., podiatrists),
- ▶ reimbursements for services included in the critical care service which should not be separately billed, and
- ▶ excessive amounts of services billed.

¹ Section 4511 of the Balanced Budget Act of 1997 removes the restriction on settings for services furnished by nurse practitioners, clinical nurse specialists and physician assistants. Payments are allowed for services furnished in all settings by these health care professionals but only if no facility or other provider charges, or is paid in connection with the service. Payment is equal to the lesser of 80 percent of the actual charge or 85 percent of the physician fee schedule.

² Current Procedural Terminology is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

METHODOLOGY

We spoke with staff from HCFA as well as staff from six regional carriers. These carriers represented 32 percent of critical care claims processed. We spoke with carrier staff regarding their processing of claims, guidance to providers, and whether they had in place processes for detection of potentially inappropriate payments for critical care codes. We further questioned staff regarding their experience with separately billed services such as x-rays and ventilator management. In addition, we reviewed relevant HCFA and Carrier Manuals regarding critical care.

In addition to our discussions with HCFA and carrier staff, we obtained 100 percent of all critical care claims for 1998 and 1999 from the National Claims History Data File maintained by HCFA. We examined claims submitted and the processing of these critical care claims. We used SAS, a statistical program, to examine whether there were unusual patterns in the use of critical care codes by specialties or locations such as emergency rooms, intensive care units, or homes. We also used these data to identify non-physicians providing critical care to beneficiaries. In addition, we identified claims for a second half-hour of critical care without a corresponding claim for the first hour of that care. We did not conduct a medical review to determine whether the billing for critical care was appropriate.

Using a 1 percent sample of all 1999 Medicare claims, we identified providers submitting claims for procedures included in the critical care payment. All findings presented in this report are based on analysis of claims data.

Our review was limited to the issues identified in the previous section. We did not conduct a medical review to determine the appropriateness or necessity of the critical care provided.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Ten physician specialties receive the majority of critical care payments

Two specialities receive over 50 percent of Medicare's reimbursement for critical care

In both 1998 and 1999, Medicare reimbursed internal medicine and pulmonary disease specialties over \$182 million in reimbursement for critical care services. Table 1 below provides the top ten specialties billing for critical care services. These specialties account for 90 percent of all critical care bills submitted to Medicare. Fifty-four different specialties split the remaining 10 percent of Medicare reimbursement for critical care.

TABLE 1

Specialty	1998		1999	
	Allowed Dollars	Percent of Dollars	Allowed Dollars	Percent of Dollars
Internal Medicine	\$112,550,171	31.72%	\$112,046,160	31.67%
Pulmonary Disease	70,997,003	20.01%	70,518,443	19.93%
Cardiology	38,646,726	10.89%	36,029,972	10.18%
Emergency Medicine	23,136,231	6.52%	24,697,832	6.98%
Family Practice	20,320,736	5.73%	20,011,506	5.66%
Critical Care Intensivists	15,667,979	4.42%	15,354,204	4.34%
Multispecialty Clinic or Group Practice	14,021,552	3.95%	14,627,546	4.13%
General Surgery	9,408,774	2.65%	9,553,924	2.70%
General Practice	9,549,761	2.69%	8,695,531	2.46%
Nephrology	8,654,139	2.44%	9,309,653	2.63%
TOTAL (10 Specialties)	\$322,953,072	91.02%	\$320,844,771	90.70%
OVERALL TOTAL	\$354,804,520	100.00%	\$353,760,445	100.00%

Source: HCFA 100 Part B Claims File

Non-physician practitioners receive a small percentage of total reimbursement for critical care services

The Balanced Budget Act of 1997 removed the restrictions on the settings in which non-physician practitioners can provide services. Some local carriers and practitioners voiced concern that non-physician practitioners were providing increasing amounts of critical care. Non-physician practitioners can provide critical care as long as they are permitted to perform such care in the State in which they are registered. In 1998,

Medicare reimbursements for critical care provided by nurse practitioners, clinical nurse specialists, and physician assistants totaled \$137,697. While reimbursement for these non-physician practitioners increased to \$325,535 in 1999, payments remain less than 0.09 percent of total spent on critical care.

Critical care services are not being unbundled

Our review of a 1 percent sample of HCFA's National Claims History file reveals few providers are submitting claims for procedures that should be included as part of the critical care payment and not be billed separately. Discussions with carriers reveal they have systems edits in place which should prevent payment for these services when performed by the same physician during the critical care period. Based on our analysis of 1999 data, we estimate that carriers allowed only 2,900 services for a total of \$51,800 that should have been bundled into the critical care payment.

Questionable payments for services have dropped

Medicare payments for the first hour of critical care (99291) have remained constant since 1996, while payments for additional time beyond the first hour in a day (99292) has dropped. Our analysis of 100 percent of critical care claims payments made in 1998 reveals that more than 34,000 claims for code 99292 critical care services without a corresponding 99291 claim (more than \$3.3 million in payments) were processed. In 1999 this figure dropped by 74 percent to 8,885 claims (\$928,034).

While most carriers advise that they have systems edits in place designed to prevent this occurrence, one carrier provided the following scenario and local policy guidance to support billing for 99292 services without a corresponding 99291. If a patient is admitted and receives 1 ¼ hours of evaluation and management care, immediately followed by ¼ hour of critical care, the physician could record 1 ¼ hours under evaluation and management and the last ¼ hour of critical care could be coded as 99292. The local policy statement reads:

Instances when a critically ill patient is seen for the first time, either as an admission E/M (evaluation and management) or on consultation or referral and this service is *immediately* followed by a period of critical care service, the physician may bill using either of these options:

- ▶ Combine and bill all services as critical care services using time spent for defining billing charges.
- ▶ Bill the admission E/M or the consultation service as a separate service from the critical care service. If this method is used, the time spent in performing the admission or consultation *cannot* be included in the critical care time billed. Furthermore, the admission or consultation service billed must meet all of the documentation and time requirements listed under CPT of those services.

Although this analysis of the local medical policy points to a potential problem, it is important to note that this carrier processed few Medicare claims and paid less than 2 percent of the national allowed dollars for critical care services in 1999. While we did not collect local policy guidance from other carriers processing critical care claims, the reduction in claims and payments for 1999 suggests this payment of 99292 without 99291 is not a common problem.

CONCLUSION

Based on our analysis, we found that very few problems exist in the specific areas of concern outlined in this report. We believe the few problems that we identified can be efficiently corrected by HCFA requesting carriers to refine payment system edits and clarify or correct local payment policy statements. Again, we must caution that we did not conduct a medical review to determine the appropriateness or necessity of the critical care provided.