Code: 99291
Basic Description: Critical Care (First hour)

Code: 99292
Basic Description: Critical care, each additional 30 minutes (list separately in addition to code 99291)

Time-based Code	Time	Age
99291	First Hour = 30-74 min	>=6 years Any age (secondary provider)
99292	Each additional 30 minutes	>=6 years Any age (secondary provider)

Description

Age:
- 6 and older (primary critical care provider)
- Any age (secondary critical care provider)
- You are the secondary provider if
    - Patient was seen in the PICU/NICU as a consult but you provided critical care services as the consultant
    - Patient was transferred to or accepted from the PICU/NICU today
    - Another service or facility will likely bill per diem critical care today

Time:
- First hour = first 30 – 74 minutes
- Additional half hour = 75 – 104 minutes
- Care > 75 minutes requires BOTH 99291 and 99292 bills
- Place a separate 99292 for each additional 30 minutes spent after the first hour
- Must document exact number of minutes, not “>30 minutes”
- Total time reflects only care you directly provided at the bedside or on the inpatient floor
- Patient was critically ill at the time care was provided

FAQ

Q: Why is the "first hour" 30 – 74 minutes?

A: In time-based billing, time is credited if you covered at least half of the given time period, but less than half of the subsequent time period.

For example, you can only bill for the first hour if you work at least 30 minutes (because 30 minutes is half of an hour).

If you exceed the first hour, you cannot bill for an additional half hour until you have provided critical care for an additional 15 minutes (because 15 minutes is half of a half hour: 60 + 15 = 75).

Clinical requirements:

- Acutely impaired functioning or failure of at least one vital organ system
- High probability of imminent or life-threatening deterioration if care is not provided

Example diagnoses:

- Acute respiratory failure (e.g., requiring HHFNC)
- acute on chronic respiratory failure (e.g., home ventilator or BiPAP patient with acute need for increased respiratory support)
- acute cardiac failure (e.g., patient on LVAD or milrinone drip)
- acute hepatic failure
- shock
- acute kidney injury
- **NOT** chronic organ failure without acute exacerbation (such as stable home ventilator patient awaiting coordination of discharge / teaching)

Example interventions:

- endotracheal intubation
- ventilator management
- HHFNC management
- BVM ventilation
- CPR
- review of monitor data
- review of blood gasses/radiographs/labs/cultures
- frequent physical examinations at bedside
- counseling caregivers about plan of care
- **NOT** discussions/meetings with the family that are not directly about the plan of care
- **NOT** activities that take place in your office (vs at bedside or on the floor)

Example autotext / dotphrase for attending note

_[***EDIT**: ID statement, reason for hospitalization or event description]

This patient is critically ill due to _[***Dropdown:** acute respiratory failure, status asthmaticus, acute cardiac failure, sepsis, acute hepatic failure, acute kidney injury]. Critical care interventions provided at the bedside or on the inpatient floor include: _[***Dropdown:** ventilator management, heated high flow nasal cannula management, BiPAP/CPAP management, continuous nebulized albuterol, management of cardiac drips, management of LVAD, review of blood gasses, review of radiographs, review of labs and/or cultures, management of enteral/parenteral nutrition, IV antibiotic therapy], continuous vital sign monitoring, close clinical monitoring under the direct supervision of a physician, and counseling caregivers about plan of care.

Plan: _

Critical care time spent: _[***EDIT:** type exact number, not ">30 "] minutes

Example autotext / dotphrase for attestation to resident note

Hospital Medicine Attending Attestation
Date of Service: _[***EDIT**]

I have personally seen and examined the patient today. I have reviewed the resident's note and agree with the documented history and physical examination as being identical to my own (except as updated or modified below). I also agree with the resident's documented plan, which I formulated together with the house staff on rounds today (except as updated or modified below).

_[***EDIT**: ID statement, supporting historical events and exam findings]

This patient is critically ill due to _[***Dropdown:** acute respiratory failure, status asthmaticus, acute cardiac failure, sepsis, acute hepatic failure, acute kidney injury]. Critical care interventions provided at the bedside or on the inpatient floor include: _[***Dropdown:** ventilator management, heated high flow nasal cannula management, BiPAP/CPAP management, continuous nebulized albuterol, management of cardiac drips, management of LVAD, review of blood gasses, review of radiographs, review of labs and/or cultures, management of enteral/parenteral nutrition, IV antibiotic therapy], continuous vital sign monitoring, close clinical monitoring under the direct supervision of a physician, and counseling caregivers about plan of care.

Plan: _

Critical care time spent: _[***EDIT:** type exact number, not ">30"] minutes

Documentation requirements for teaching physician

- That the patient was critically ill during the time the teaching physician saw the patient
- What made the patient critically ill
- The nature of treatment and management provided by the teaching physician
- Documenting critical care services requires more than a standard attestation from the faculty when seeing the patient with a resident or fellow
- Documentation should state: “Patient requires critical care for _____” or a similar phrase
- Diagnoses must support need for critical care and be as specific as possible