There is considerable confusion when combining NPP and physician time for critical care. This is addressed in the Medicare Claims Processing Manual, Chapter 12 30.6.12 (Rev. 2914, 03-25-14). The confusion generally revolves around shared billing and critical care. To further clarify, shared billing is evaluation and management (E/M) care that is performed by both a physician and qualified NPP. This is addressed in the Medicare Claims Processing Manual, Chapter 12 30.6.1, section B (Rev. 2014, 03-25-14).

When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s UPIN/PIN.

To further reinforce this, Medicare states in Chapter 12 30.6.1, section E (Critical Care Services and Physician Time):

- A split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) cannot be reported as a critical care service. Critical care services are reflective of the care and management of a critically ill or critically injured patient by an individual physician or qualified non-physician practitioner for the specified reportable period of time.

Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment, and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP.

When CPT code time requirements for both 99291 and 99292 and critical care criteria are met for a medically necessary visit by a qualified NPP the service shall be billed using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services.

This leads to confusion over how to bill for time when both a physician and NPP from the same practice and specially perform critical care services on the same patient on the same day. Medicare clarifies this in Chapter 12 30.6.12, section I (Critical Care Services Provided by Physicians in Group Practice(s)):

However, if a physician or qualified NPP within a group provides “staff coverage” or “follow-up” for each other after the first hour of critical care services was provided on the same calendar date by the previous group clinician (physician or qualified NPP), the subsequent visits by the “covering” physician or qualified NPP in the group shall be billed using CPT critical care add-on code 99292. The appropriate individual NPI number shall be reported on the claim. The services will be paid at the specific physician fee schedule rate for the individual clinician (physician or qualified NPP) billing the service.

Because of this confusion, different Medicare administration contractors have developed different policies for dealing with physicians and NPPs billing critical care on the same patient on the same day. Private payers and state Medicaid payers also may have different policies. Providers are urged to contact their carrier to clarify critical care payment methodology for combining NPP and physician critical care time.

Early detection of sepsis, with the timely administration of appropriate antibiotics, appears to be the single most important factor in reducing morbidity and mortality from sepsis. The Society of Critical Care Medicine is partnering with The Johns Hopkins University School of Medicine to offer a one-day interactive conference which will focus on strategies to identify, diagnose and manage patients who present with signs and symptoms of sepsis, irrespective of their care unit.

It has become increasingly apparent that there is a long delay in both the recognition of sepsis and the initiation of appropriate therapy in many patients. This translates into an increased incidence of progressive organ failure and a higher mortality. Healthcare providers, therefore, need to have a high index of suspicion for the presence of sepsis and must begin appropriate antimicrobials quickly. Join the multiprofessional panel of leading experts who will focus on problem solving through case studies in developing effective strategies in specific patient populations.

Register at www.sccm.org/Sepsis.

Learning Objectives

- Identify cutting-edge diagnostic algorithms for pathogen identification in sepsis
- Analyze and implement sepsis care pathways for patients who are not yet located in the ICU
- Compare and contrast efficacy of current infection control practices
- Summarize effective antibiotic recommendations for common nosocomial infections

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