ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-6
PHYSICIANS PROGRAM

560-X-6-.18 Critical Care.

(1) When caring for a critically ill patient in which the constant attention of the physician is required, the appropriate critical care procedure code must be billed. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidance and clarification.

(2) The actual time period, per day, spent in attendance at the patient's bedside, or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

(3) Only the following individual procedures related to critical care may be billed:

(a) Procedure code 99360 (stand by) and either procedure code 99221, 99222, or 99223 (initial hospital care) may be billed once with each hospital stay.

(b) An EPSDT screening may be billed in lieu of the initial hospital care (Procedure code 99221, 99222, or 99223).

(c) Procedure code 99082 (transportation/escort of patient) may be billed only by the attending physician. Residents or nurses who escort a patient may not bill either service.

(4) Pediatric and Neonatal Critical Care. The purpose of the following policy statements is to provide assistance to providers seeking to bill procedures for critical care. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidance and clarification.

(a) Pediatric and neonatal critical care codes begin with the day of admission and may be billed once per patient, per day, in the same facility.

(b) The pediatric and neonatal critical care codes include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

(c) Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes should be billed.

(d) Refer to the Alabama Medicaid Provider Manual for guidelines on what additional procedures may be billed in conjunction with critical care. General guidelines are:

1. Initial history and physical or EPSDT screen may be billed in conjunction with 99293 or 99295. Both may not be billed. One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.

2. Standby (99360) or resuscitation (99465) at delivery or attendance at delivery (99464) may be billed in addition to critical care. Only one of the codes may be billed in addition to critical care.

3. Subsequent Hospital Care codes (99231-99233) may not be billed.

4. Critical care is considered to be an evaluation and management service. Although usually furnished in a critical or intensive care unit, critical care may be provided in any inpatient health care setting. Services provided which do not meet critical care criteria should be billed under the appropriate hospital care codes. If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU/ICU critical care codes to be billed again.

5. Transfers to the pediatric unit from the NICU cannot be billed using neonatal critical care codes.

6. Global payments encompass all care and procedures which are included in the rate. Physicians may not perform an EPSDT screen and refer to partner or other physician to do procedures. All procedures which are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.

7. Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as defined in the Alabama Medicaid Provider Manual. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary

attending physician for the patient. Consultation and critical care cannot be billed on the same patient on the same day.

(5) Intensive (Non-Critical) Low Birthweight Services. The purpose of the following policy statement is to provide assistance to neonatology providers seeking to bill for intensive (non-critical) low birthweight services. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidelines and clarification. Intensive (non-critical) low birthweight services codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birthweight infant who no longer meets the definition of being critically ill. Low birthweight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting.

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