Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: Modifier -25 Is Not Required for 99291 Payment

Question: When billing for critical care visits, should I use different diagnosis codes for 99291 and 99292? If I report critical care and two separate procedures, should I attach modifier -25 to both 99291 and 99292?

Oregon Subscriber

Answer: You can use the same ICD-9 code for both 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and +99292 (... each additional 30 minutes ...). When you attach add-on code 99292 to 99291, you are reporting the additional time the physician spent providing critical care. Consequently, you do not have to assign a new code for a new condition when you list the add-on code.

For example, your internist treats a patient with heart failure (428.x) for 45 minutes. If the documentation supported critical care, you could report 99291, using 428.x as your justification. You would use 99292 only if the internist's care for the heart failure lasted at least 104 minutes.

Both CPT and Medicare bundle several procedure codes, such as 92953 (Temporary transcutaneous pacing), into the critical care codes. Therefore, you shouldn't attach modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to 99291-99292.

But if you are reporting a procedure code that CPT doesn't bundle into critical care (for instance, 93000, Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report), you could bill the codes separately without modifiers.