		Fee

LIFE THREATENING CRITICAL CARE

The service rendered when a physician provides critical care to a critically ill or critically injured patient. For the purpose of this service, a critical illness or critical injury is one that acutely impairs one or more vital organ system(s) causing vital organ system failure as a result of which imminent life threatening deterioration in the patient's condition is highly probable.

[Commentary:
Examples of vital organ system failure include but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and or respiratory failure.]

Amount payable per physician per patient for the first three physicians:

G521	- first ¼ hour (or part thereof)	110.55
G523	- second ¼ hour (or part thereof)	55.20
G522	- after first ½ hour, per ¼ hour (or part thereof)	36.35
G391	Amount payable per physician per patient for the fourth and subsequent physicians (per ¼ hour or part thereof)	28.35

The following services are *not eligible for payment* when rendered to the same patient by the same physician on the same *day* as any code described as "life threatening critical care":

1. Assessment and ongoing monitoring of the patient's condition.
2. Intravenous lines.
3. Cutdowns.
4. Arterial and/or venous catheters.
5. Central venous pressure (CVP) lines.
6. Endotracheal intubation.
7. Tracheal toilet.
8. Blood gases.
9. Nasogastric intubation with/without anaesthesia with/without lavage.
10. Urinary catheters.
11. Pressure infusion sets and pharmacological agents.
12. Defibrillation.
13. Cardioversion.

Payment rules:

1. The time unit is measured as the physician time spent fully devoted to the care of the patient and excludes time spent on separately billable interventions on the patient receiving the "life threatening critical care". The service is *only eligible for payment* for services rendered by the physician at the bedside or in the emergency department or on the hospital floor where the patient is located. Time unit total *may include* time which is consecutive or non-consecutive.
2. During the time reported for which any of these codes is claimed, the physician cannot provide services to other patients.
3. "Life threatening critical care" is *not eligible for payment* for the services of a physician rendered to the same patient on the same *day* for which the physician is paid a per diem fee for Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.
4. Consultation or assessments rendered before or after provision of "life threatening critical care" may be eligible for payment on a fee-for-service basis but not when claiming Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care per diem fees.

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

[Commentary:
Time unit total *may include* time which is consecutive or non-consecutive.]

Fee

OTHER CRITICAL CARE

The service rendered when a physician provides resuscitation assessment and procedures in an emergency in circumstances other than those described as "life threatening critical care", where there is a potential threat to life or limb of such a type that without resuscitation efforts by the physician, there is a high probability the patient will suffer loss of limb or require "life threatening critical care".

Amount payable per physician per patient for the first three physicians:

G395	- first ¼ hour (or part thereof)	56.80
G391	- after first ¼ hour per ¼ hour (or part thereof).....	28.35

The following services are *not eligible for payment* when rendered to the same patient by the same physician on the same *day* as any code described as "other critical care":

1. Assessment and ongoing monitoring of the patient's condition.
2. Intravenous lines.
3. Cutdowns.
4. Arterial and/or venous catheters.
5. Central venous pressure (CVP) lines.
6. Endotracheal intubation.
7. Tracheal toilet.
8. Blood gases.
9. Nasogastric intubation with/without anaesthesia with/without lavage.
10. Urinary catheters.
11. Pressure infusion sets and pharmacological agents.

Payment rules:

1. G395 is *not eligible for payment* with G521, G522 or G523 for services rendered to the same patient by the same physician on the same *day*.
2. The time unit is measured as the physician time spent fully devoted to the care of the patient and excludes time spent on separately billable interventions on the patient receiving "other critical care". The service is *only eligible for payment* for services rendered by the physician at the bedside or in the emergency department or on the hospital floor where the patient is located. Time units *may include* time which is consecutive or non-consecutive.
3. During the time reported for which any of these codes is claimed, the physician cannot provide services to other patients.
4. "Other critical care" is *not eligible for payment* for the services of a physician rendered to the same patient on the same *day* for which the physician is paid a per diem fee for Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.
5. Consultation or assessments rendered before or after provision of "other critical care" may be eligible for payment on a fee-for-service basis but not when claiming Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care per diem fees.

Medical record requirements:

The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

[Commentary:

Time unit total *may include* time which is consecutive or non-consecutive.]

CRITICAL CARE

		Fee

[Commentary:
Life threatening critical care and other critical care
The duration of "life threatening critical care" and "other critical care" services that physicians should document is the time they actually spend evaluating, managing, and providing care to the critically ill or injured patient to the exclusion of all other work.

For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be included in the definition of critical care, even when it does not occur at the bedside, if this time represents their full attention to the management of the critically ill/injured patient.

Time spent involved in activities in any location other than the bedside, emergency department or hospital floor where the patient is located cannot be claimed as the physician is not immediately available to the patient.

Submit claims manually when the total time spent in providing "life threatening critical care" or "other critical care" is greater than two (2) hours.]

G303	Transthoracic pacemaker - insertion	51.25
G211	Endotracheal intubation for resuscitation (not to be claimed when followed by a surgical procedure at which time it is included in the anaesthetic procedure) ...	38.35

CRITICAL CARE PER DIEM LISTINGS

A. The fees under physician-in-charge (the physician(s) daily providing the critical care services) apply per patient treated, i.e. while the physician-in-charge may change during the course of treatment, the daily fee formula as set out should be claimed by the physicians involved as if there was only one physician-in-charge during the treatment program; in this sense, the daily fees are team fees.

B. When claiming Critical, Ventilatory, Neonatal Intensive Care or Comprehensive Care fees no other Critical Care codes may be paid to the same physician(s).

C. Other physicians other than those providing Critical Care or Comprehensive Care may claim the appropriate consultation, visit and procedure fees not listed in the fee *schedule* for Critical Care. These claims will be adjudicated by the *Medical Consultant* in an Independent Consideration basis.

D. If Ventilatory Support only is provided, for example, by the anaesthetist(s), claims should then be made under Ventilatory Support. Comprehensive Care and Neonatal Intensive Care fees do not apply.

E. Other physicians should then claim Critical Care fees or the appropriate consultation, visit or procedures.

F. If the patient has been discharged from the Unit more than 48 hours and is re-admitted to the Unit, the 1st *day* rate applies again on the *day* of re-admission.

G. The appropriate consultation, assessment and procedural benefits apply after stopping Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.

H. Unless otherwise stated, the Critical Care per diem fees should not be claimed for stabilized patients and those patients who are in an intensive care unit for the purposes of monitoring. The appropriate consultation, assessment and procedural benefits apply.

			Fee

CRITICAL CARE (INTENSIVE CARE AREA)

Critical Care is the service rendered by a physician for providing, in an Intensive Care Area, all aspects of care of a critically ill patient excluding ventilatory support and includes initial consultation and assessment, emergency resuscitation, intravenous lines, cutdowns, intraosseous infusion, pressure infusion sets and pharmacological agents, insertion of arterial, C.V.P. or urinary catheters and nasogastric intubation *with or without* anaesthesia, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases, and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device). Except when a patient is on a ventilator, these fees are not payable for services rendered to stabilized patients in I.C.U.s, or patients admitted for ECG monitoring or observation alone. If the patient has been transferred from comprehensive care to critical care, the *day* of the transfer shall be deemed for payment purposes to be the second *day* of critical care.

Physician-in-charge

#	G400	- 1st day		223.10
#	G401	- 2nd to 30th day, inclusive	per diem	146.45
#	G402	- 31st day onwards	per diem	58.60

VENTILATORY SUPPORT (INTENSIVE CARE AREA)

Ventilatory Support includes provision of ventilatory care including initial consultation and assessment of the patient, intravenous lines, endotracheal intubation with positive pressure ventilation including insertion of arterial C.V.P lines, tracheal toilet, use of artificial ventilator and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, transcutaneous blood gases and assessment. If the patient has been transferred from comprehensive care to ventilatory care, the *day* of the transfer shall be deemed for payment purposes to be the second *day* of ventilatory care.

Physician-in-charge

#	G405	- 1st day		193.45
#	G406	- 2nd to 30th day, inclusive	per diem	101.55
#	G407	- 31st day onwards	per diem	67.60

COMPREHENSIVE CARE (INTENSIVE CARE AREA)

Comprehensive Care is the service rendered by an Intensive Care physician who provides complete care (both Critical Care and Ventilatory Support as defined above) to Intensive Care Area patients. This service includes the initial consultation and assessment and subsequent examinations of the patient, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, cutdowns, intraosseous infusion, arterial and/or venous catheters pressure infusion sets and pharmacological agents, insertion of C.V.P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric intubation *with or without* anaesthesia, securing and interpretation of blood gases and laboratory tests, oximetry, transcutaneous blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device). Except when a patient is on a ventilator, these fees are not payable for services rendered to stabilized patients in I.C.U.s or patients admitted for E.C.G. monitoring or observation alone. If the patient has been transferred from critical care to comprehensive care, the *day* of the transfer shall be deemed for payment purposes to be the second *day* of comprehensive care.

Physician-in-charge

#	G557	- 1st day		325.40
#	G558	- 2nd to 30th day, inclusive	per diem	213.50
#	G559	- 31st day onwards	per diem	85.35