

CRITICAL CARE

Complete understanding of the following paragraphs is essential to appropriate billing of the critical care fees. Members of the team billing the Critical Care Payment Schedule can not be receiving other payments (e.g.: fees, alternative or sessional payments) for the clinical care of the patient.

Preamble

Adult and Pediatric Critical Care

These listings do not apply to the non-ventilated stable patients admitted to a special care unit for routine post-op care, or for nursing care reasons, cardiac or other monitoring. The Critical Care Payment Schedule is intended to be used by physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment, such as ventilatory support, haemodynamic support including vasoactive medications, or prolonged resuscitation.

Day 1 billing is to be used only when more than 2 hours of bedside care is provided. (If 01411 – 01413 billed in isolation, a total of 2 hours care on the first day is required. If critical and ventilatory care is billed conjointly by the team, then each component must be a minimum of 1 hour of care). Day 1 is defined as starting at 0000 hours. If a patient is seen after 2200 hours, the physician may bill emergency care services, (00081/00082) or a major consultation fee with resuscitation services, (00081), or a major consultation fee with additional visits when appropriate. Day 2 billing would start at 0000 hours the next day. Standby time is not allowed.

It is recognized that a team of physicians often manages complicated problems in the Intensive Care Unit. The schedule is a team fee and individual members of the team who share a common call rotation may not bill separately. The original physician or physicians providing initial bedside care will be designated physician or physicians in charge, i.e. if it is a single physician then the comprehensive or critical care item may be billed when appropriate. If two physicians are involved then the critical care item and ventilatory support item may be billed, if the other requirements are met. Critical care billing no longer applies when the services indicated in the listings are no longer required. If the patient has been discharged from the unit and is readmitted within 48 hours with the same or a similar problem, billing would continue from where it was stopped. After 48 hours, billing would usually start at Day 2 rates. If problem is totally different, Day 1 rates will apply regardless of time admitted both within or after 48 hours (a note record is required).

Since these listings are intended to cover all required services for critically ill patients, no other physician except the Primary Care Physician (who may bill for daily or supportive care) may bill for the care of the patient on the same day, except for:

- Consultation fee to a specialist outside the team when requested (service not within the competence or specialty of a team member). Follow-up visits may be billed only if the physician is involved in the active care of the patient.
- TPN when ordered by a physician not part of the critical care team.
- Medical management of Extra Corporeal Membrane Oxygenation (ECMO) should be billed as a miscellaneous fee, and will be paid in equity with the Critical Care daily fees (1411/21/31/41), starting at Day 1.
- The Critical Care team member who performs ECMO cannot concurrently bill the daily fees on the same patient. Another physician on the team may concurrently bill the appropriate Adult and Pediatric Critical Care daily fees on that patient.

- Continuous Renal Replacement Therapy (CRRT, also referred to as dialysis) and MARS (Molecular Adsorbents Recirculating System) may be paid in addition to Critical Care daily fees to the same physician or to another member of the Critical Care Team. For the CCM Physician, these fees will be paid at 75% of fee item 33750, 33751, 33752 and 33758, and will follow the billing rules under these dialysis fees.
- Dialysis, when supervised by a physician not part of the Critical Care Team, will be paid at 100%.
- In exceptional circumstances other physicians may be called in to perform specific procedures usually managed by the critical care team, i.e. anesthesiologist (not a member of the team) called to insert a difficult arterial line when no one else is capable of performing the procedure. That physician may bill the procedure fee but a consultation fee would not be applicable.

A note record is required explaining the need for services outside the critical care team.

Subsequent Major surgical procedures rendered by a physician who is on the team billing under the critical care schedule are payable at 75% (operation only procedures payable at 100%) and should be billed accordingly.

Postoperative surgical care is included in the surgeon's fee. Critical care fees are not applicable for services rendered to routine, stable patients who are simply recovering from surgery. The following is applicable for members of the critical care team, in cases where the patient requires critical care following surgery:

- (a) Services rendered to unstable, critically ill non-elective post-surgical patients who meet normal Day 1 criteria should be billed at Day 1 rates.
- (b) Services rendered to high risk and unstable patients, (particularly after emergency surgery) who warrant ICU care but who do not meet the requirement of two hours of direct critical care management on their first day in ICU, should be billed using the appropriate consultation and procedural item(s). Subsequent day, Day 2 rates are applicable.
- (c) Where the patient requires critical care following uncomplicated elective surgery, the critical care fees may be billed by the critical care team utilizing Day 2 rates. The operating surgeon(s) may bill the critical care fee guide but the preceding major surgical procedure will be reduced to 75%.
- (d) The critically ill patient, who, following elective surgery, has an unusual and unexpected problem, can be billed as Day 1. A note record is required.

Critically ill patients are occasionally transferred from one hospital to another. Under such circumstances the original intensive care team may bill for the day of the patient's transfer, if appropriate. First day rates would apply to the receiving intensive care team if more than two hours of bedside care are provided. This does not apply to intra-hospital transfers. Please also provide in a "note record" the statement that "patient transferred from _____ Hospital".

Physicians required to be in attendance during the transporting of a patient from a critical care area to an outside institution may claim the appropriate fee (e.g.: 00084).

These Critical Care listings only apply to physicians who are directly involved in the bedside care of patients as defined in the "Preamble to the Payment Schedule".

“C. 18. Guidelines for payment for services by residents and/or interns.

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the medical practitioner responsible shall be personally identified to the patient at the earliest possible moment. No fees may be charged in the name of the responsible staff physician for services rendered by an intern or resident prior to the identification taking place. Moreover, the responsible staff physician must be in the clinical teaching unit and/or immediately available to intervene (immediately available means on-site).

For a medical practitioner who supervises two or more procedures or other services concurrently through the use of residents, interns or other members of the team, total billings must not exceed the amount that a medical practitioner could bill in the same time period in the absence of the other team members.”

Out-Of-Office Hours Call-out charges and Surcharges and emergency visit fees are not payable in addition to this schedule, as historically, these fees are included in the critical care fees.

Referred Cases

01400 Consultation: to consist of examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report (not for ICU patients)166.70
Note: Restricted to Critical Care physicians.

01402 Repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee (not for ICU patients)79.41
Note: Restricted to Critical Care physicians.

Continuing care by consultant:

01408 Subsequent hospital visit (not for patients in an ICU)28.37
Note: Restricted to Critical Care physicians.

01469 Direction of care/end of life Assessment166.70
Notes:

- i) Restricted to Critical Care physicians who have not treated the patient in the previous seven days.
- ii) This fee includes an examination, review of history, laboratory. X-ray findings necessary to write a report as well as any and all meetings with family and ICU team required to formulate and perform end-of-life and/or direction of care, e.g.: withdrawal of life-sustaining measures and filling out forms for comfort care orders.
- iii) Patient must be in ICU with life threatening illness.
- iv) Not intended for use for advance-care planning.
- v) Limited to one assessment per patient per ICU admission.

Telehealth Service with Direct Interactive Video Link with the Patient:

01470 Telehealth Consultation: to consist of examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report (not for ICU patients)166.70
Note: Restricted to Critical Care physicians.

01472 Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee (not for ICU patients)79.41
Note: Restricted to Critical Care physicians.

Adult and Pediatric Critical Care

1. **CRITICAL CARE** – includes provision in an Intensive Care Area of all aspects of care of a critically ill patient excluding ventilatory support and includes initial consultation and assessment, family counselling, emergency resuscitation, intravenous lines, bronchoscopy, chest tubes, lumbar puncture, cut-downs, pressure infusion set and pharmacological agents, insertion of arterial C.V.P., Swan-Ganz or urinary catheters and nasogastric tubes, defibrillation, cardio version and usual resuscitative measures, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device). There is an expectation of at least 1 hour of bedside care on Day 1. These fees are not chargeable for services rendered to stabilized patients in ICU's for example, routine post-op monitoring, or patients admitted for ECG monitoring or observation alone.

**Total
\$ Fee**

Physician-in-charge is the physician(s) daily providing the above.

01411	1st day	331.77
01421	2nd to 7th day (inclusive) per diem	169.21
01431	8th day to 30th day	86.08
01441	31st day onward	27.72

2. VENTILATORY SUPPORT - includes provision of ventilatory care including initial consultation and assessment of the patient, family counselling, cut-down, pressure infusion, insertion arterial & CVP, Swan-Ganz, tracheal toilet, endotracheal intubation, intravenous lines, artificial ventilation and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, end tidal CO₂, transcutaneous blood gas application and assessment and maximum inspiratory pressure monitoring and non-invasive metabolic measurements. There is an expectation of at least 1 hour of bedside care on Day 1. This is the fee to use when one physician is providing the ventilatory care and another physician, the critical care. This service may also be billed by a physician other than the operating surgeon or associate, for critical care required in addition to postoperative care by the surgeon.

Physician-in-charge is the physician(s) daily providing the above.

01412	1st day	289.27
01422	2nd to 7th day (inclusive) per diem	147.04
01432	8th day to 30th day	99.79
01442	31st day onward	36.16

3. COMPREHENSIVE CARE - These fees apply to intensive care physicians who provide complete care, both Critical Care and Ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment and subsequent examinations of the patient, family counselling, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, bronchoscopy, chest tubes, lumbar puncture, cut-downs, arterial and/or venous catheters, insertion of a Swan-Ganz catheter, pressure infusion sets and pharmacological agents, insertion of C.V.P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric tubes, securing and interpretation of blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device). There is an expectation of at least 2 hours of bedside care on Day 1. These fees are not chargeable for services rendered to stabilized patients in the ICU's or patients admitted for ECG monitoring and observations.

Physician-in-charge is the physician(s) daily providing the above.

01413	1st day	549.61
01423	2nd to 7th day (inclusive) per diem	251.68
01433	8th day to 30th day	127.85
01443	31st day onward	63.28

If ventilatory support only is provided, claims should then be made under Ventilatory Support. Comprehensive Care fees do not apply. Other physicians should then charge Critical Care fees, if applicable, or the appropriate consultation, visit or procedure fees.

Neonatal Intensive Care

These listings may be used for patients receiving neonatal intensive care and are intended for use by the Neonatologist or Pediatrician (or Team) in charge of the patient. These listings may be used by physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment such as ventilatory support, haemodynamic support including vasoactive medications or prolonged resuscitation. They are to be billed only on sick or preterm infants requiring intensive care. They are also for infants who are more than 28 days old, who have neonatal problems related to prematurity, etc. These listings do not apply to non-ventilated stable patients admitted to a special care unit for routine post-op care. These fees are not for the infant who is stable and only requiring a period of observation. Neither are they for the infant who needs a short course of prophylactic antibiotics. It would be unusual to bill these fees on an infant whose period of care in the NICU lasted less than 48 hours. Consultation and visit fees would be appropriate.

These neonatal intensive care fees only apply to physicians who are directly involved in the bedside care of patients in the Critical Care Areas. "Preamble to the Payment Schedule" applies:

"C. 18. Guidelines for payment for services by residents and/or interns.

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the medical practitioner responsible shall be personally identified to the patient at the earliest possible moment. No fees may be charged in the name of the responsible staff physician for services rendered by an intern or resident prior to the identification taking place. Moreover, the responsible staff physician must be in the clinical teaching unit and/or immediately available to intervene (immediately available means on-site).

For a medical practitioner who supervises two or more procedures or other services concurrently through the use of residents, interns or other members of the team, total billings must not exceed the amount that a medical practitioner could bill in the same time period in the absence of the other. These neonatal intensive care fees only apply to physicians who are directly involved in the bedside care of patients in the Critical Care Areas. "Preamble to the Payment Schedule" applies:

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included are: family counselling, emergency resuscitation, insertion of arterial, venous, Swan-Ganz, CVP or urinary catheters, intravenous lines, interpretation of blood gases, insertion of nasogastric tubes, infusion of pharmaceutical agents including TPN, endotracheal intubation and artificial ventilation and all other necessary respiratory support. Exchange transfusion is not included in these fees and not all infants requiring an exchange transfusion are critically ill.

Out-Of-Office Hours Call-out Charges may still apply for special calls back to the hospital and may be billed in conjunction with a no charge visit. If a patient is discharged from the unit for more than 48 hours and is readmitted, second day rates again apply. If the patient is re-admitted within 48 hours of discharge, billing continues under fee code billed at discharge, unless acuity level changes. If a patient changes acuity level up or down then the appropriate second day rate applies. A note record is required indicating the change in acuity level. Fee item 00505 (Emergency Visit) may not be billed by the person claiming these fees.

Call-out charges are billable with the neonatal critical care fee items. Historically, these have not been included in the neonatal fees and may be billed separately.

Members of the team billing the Neonatal Guide cannot be receiving other payments (e.g.: fees, alternative or sessional payments) for the clinical care of the patient.

**Total
\$ Fee**

LEVEL A - Infants in a Neonatal Intensive Care Unit requiring artificial ventilation and full intensive monitoring and parenteral alimentation if necessary. These fees include all necessary procedures.

01511	Day 1	610.86
01521	Day 2 - 10	244.32
01531	Day 11 onward	162.91

LEVEL B - Infants in a Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive and requiring IV therapy or parenteral alimentation but without ventilator support.

01512	Day 1	448.00
01522	Day 2 - 10	162.91
01532	Day 11 onward	121.05

LEVEL C - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.

01513	Day 1	386.87
01523	Day 2 - 10	119.56
01533	Day 11 onward	69.46