Statement on the Role of Anesthesiologists in the Practice of Adult Critical Care Medicine

Committee of Origin: Critical Care Medicine

(Approved by the ASA House of Delegates on October 13, 2021)

I. Current state of adult critical care services provided in the United States.

CMS\(^1\) sets forth the following conditions to reimburse for services reported with CPT codes 99291 and 99292: “Critical care is defined as the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition. 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.

Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life-threatening situations when these elements are not present. Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care.”

Of note, a physician may bill critical care time, irrespective of subspecialty certification. Indeed, critical care is frequently billed by non-intensivists:\(^2\)
Table 1 depicts results of an analysis of Medicare data from 2007 using the 5% sample from the Standard Analytic Carrier File that includes de-identified data for a random 5% sample of Medicare beneficiaries 65 years of age or older (Evans et al., 2011 with permission from author).

II. Critical care medicine-relevant training within the ACGME core curriculum

Although fellowship training in critical care medicine is not a pre-requisite to providing critical care services, anesthesiologists may pursue such training. The ACGME Program Requirements for Graduate Medical Education in Anesthesiology specify that "an anesthesiologist is skilled in the management and diagnosis of critically-ill patients, including those experiencing cardiac arrest". Training includes mandatory critical care times in the core residency program: "Resident education must include a minimum of four one-month rotations in critical care medicine. Each critical care medicine rotation must be at least one month in duration, with progressive patient care responsibility in advanced rotations. Training must take place in units, providing care for both men and women, in which the majority of patients have multisystem disease. Residents must actively participate in all patient care activities as fully integrated members of the critical care team." Indeed, intraoperative management meets the definition of critical care, so anesthesiologists already have the skills required for...
critical care but normally use these skills in the operating room rather than the intensive care unit.

III. Anesthesiology-subspecialty training in critical care medicine

The ACGME Program Requirements for Graduate Medical Education in Anesthesiology Critical Care Medicine state that a 12-month fellowship in anesthesiology critical care medicine fellowship provides advanced knowledge, skills, and clinical experiences in critical care medicine to foster the practice of multidisciplinary critical care, including both medical and surgical critical care medicine. According to a 2018 publication, amongst all specialties offering subspecialty training in critical care, anesthesiology has seen one of the largest increases in the number of residents, from 48 in 2001 to 194 in 2017 (75.3% increase) despite a minimal increase in programs (from 53 to 58).

IV. Utilization of anesthesiologists as part of a national surge capacity strategy to expand critical care medicine capacities

During the COVID-19 pandemic, anesthesiologists in the United States and around the world stepped up to close precarious gaps in medical care. Indeed, anesthesiologists are uniquely qualified to provide critical care services to patients afflicted by severe forms of COVID-19 disease. In the context of the recent COVID-19 pandemic response, the following considerations are suggested:

1) We encourage subspecialty fellowship training for critical care.
2) We welcome multidisciplinary approaches to critical care medicine practice, including multispecialty training.
3) As members of a multidisciplinary team, anesthesiologists represent an additional resource to provide critical care services in times of heightened need ranging from a medical emergency on a general medical floor to natural disasters or future pandemics.
4) Anesthesiologists should be aware of and trained in applying appropriate billing for critical care-related services they provide. Examples of such CPT billing codes that are used in the United States are:
   a. 92950: CPR - provision of cardiac life support including ventilation and chest compressions and ventilation.
   b. 99291 Critical Care Services (30-74 minutes) and 99292 (each additional 30 minutes). Two conditions have to be met: 1) the patient has to be critically ill, and 2) the care provided requires direct involvement and management by the provider.
References:


