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Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

Note: This article was revised on July 23, 2008, to reflect additional changes made to CR5993 on July 9. CR5993 was revised to correctly state the payment policy regarding emergency department visits on the same day as critical care services for the same patient by the same physician, to clarify reporting of services supplied to neonates, infants, and children by referring providers to consult the American Medical Association's Current Procedural Terminology, and to correct the information on how to calculate critical care time from the paragraph before the table on page 6 of this article. There are additional minor clarifications.

Provider Types Affected

Physicians and Qualified Non-Physician Practitioners (NPP) who bill Medicare carriers and Medicare Administrative Contractors (A/B MAC) for critical care services provided to Medicare beneficiaries.

What You Need to Know

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CR 5993, from which this article is taken, revises the *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.12. (Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)), replacing all previous critical care payment policy language in the section and adding general Medicare evaluation and management (E/M) payment policies that impact payment for critical care services.

Specifically, CR 5993:

- Explains the definition of, and how to bill for, critical care services, and includes the American Medical Association (AMA) Current Procedural Terminology (CPT) definitions of critical care and critical care services.
- Adds a new CPT code for 2008 (36591) which replaces code 36540. Code 36591 identifies a bundled vascular access procedure when performed with a critical care service.

Make sure that your billing staffs are aware of these revisions.

Background

CR 5993, from which this article is taken, explains the definition of critical care services and how to correctly bill for these services. It discusses medically necessary services, full physician attention, counting the hours of critical care billing, performance of other evaluation and management (E/M) services on the same day as critical care services, group practice issues, services by a qualified nonphysician practitioner (NPP), bundled procedures, global surgery issues, ventilation management, teaching physician issues, physician services off the unit/floor, split/shared services, unbundled procedures, and inappropriate use of time and family counseling and discussions.

The following summarizes the information contained in CR 5993 and in *Medicare Claims Processing Manual* Chapter 12, Section 30.6.12, which is an attachment to CR5993.

Use of Critical Care Codes (CPT codes 99291-99292)

Critical care is defined as a physician's (or physicians') direct delivery 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 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;

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- Circulatory failure;
- Shock;
- Renal, hepatic, metabolic, and/or respiratory failure.

Although it 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.

You should remember that 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. While critical care is usually given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department, payment may also be made for critical care services that you provide in any location as long as this care meets the critical care definition.

When all these criteria are met, Medicare contractors (carriers and A/B MACs) will pay for critical care and critical care services that you report with CPT codes 99291 and 99292 (described below).

Critical Care Services and Medical Necessity

Critical care services must be reasonable and medically necessary. As explained above, critical care services encompass both the treatment of “vital organ failure” and “prevention of further life threatening deterioration in the patient’s condition.” Therefore, delivering critical care in a moment of crisis, or upon being called to the patient’s bedside emergently, is not the only requirement for providing critical care service. Treatment and management of a patient’s condition, in the threat of imminent deterioration; while not necessarily emergent, is required.

In this context, examples of patients whose medical conditions may warrant critical care services would include:

1. An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and vasopressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
2. A 67 year old female patient is three days status post mitral valve repair. She develops petechiae, hypotension, and hypoxia requiring respiratory and circulatory support.
3. A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive two days after admission.
4. A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

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You should not consider that the provision of care to a critically ill patient is automatically a critical care service just because the patient is critically ill or injured. To this point, each physician providing critical care services to a patient during the critical care episode of an illness or injury must be managing one or more of the critical illness(es) or injury(ies) in whole, or in part.

In this context, examples of scenarios in which a patient's medical condition may not warrant critical care services would include:

1. A dermatologist evaluating and treating a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist.
2. Daily management of a patient on chronic ventilator therapy unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.
3. Management of dialysis or care related to dialysis for a patient receiving End Stage Renal Disease (ESRD) hemodialysis, unless the critical care is separately identifiable from the chronic long term management of the dialysis dependence (Refer to *Medicare Claims Processing Manual*, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 160.4 (Requirements for Payment)).

Note: When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed it may be billed as critical care, if critical care requirements are met. Modifier –25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) should be appended to the critical care code when applicable in this situation.

Similarly, examples of patients who may not satisfy Medicare medical necessity criteria for critical care payment would include:

- Patients admitted to a critical care unit because no other hospital beds were available,
- Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose), or
- Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

You should consult the American Medical Association (AMA) CPT Manual for the applicable codes and guidance for critical care services provided to neonates, infants and children.

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Critical Care Services and Full Attention of the Physician

The duration of critical care services that physicians should report is the time you actually spend evaluating, managing, and providing the critically ill, or injured, patient's care. Be aware that during this time, you cannot provide services to any other patient, but rather must devote your full attention to this particular critically ill patient.

This time must be spent at the patient's immediate bedside or elsewhere on the floor, or unit, so long as you are immediately available to the patient. 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 reported as critical care, even when it does not occur at the bedside; if this time represents your full attention to the management of the critically ill/injured patient.

Note: Time spent off the unit or floor where the critically ill/injured patient is located (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) floor may not be reported as critical care time because the physician is not immediately available to the patient. This time is regarded as pre- and post service work bundled in evaluation and management services.

Critical Care Services and Qualified Non-Physician Practitioners (NPP)

Qualified NPPs may provide critical care services (and report for payment under their National Provider Identifier (NPI)), when these services meet the above critical care services definition and requirements.

Notes: 1) The critical care services that NPPs provide must be within the scope of practice and licensure requirements for the State in which they practice and provide the services; and 2) NPPs must meet the collaboration, physician supervision requirements, and billing requirements; and physician assistants (PA) must meet the general physician supervision requirements.

Critical Care Services and Physician Time

Critical care is a time- based service. Payment for critical care services is not restricted to a fixed number of hours, days, or physicians (on a per-patient basis) when such services meet medical necessity; and time counted toward critical care services may be continuous clock time or intermittent in aggregated time increments (e.g. 50 minutes of continuous clock time or five ten minute blocks of time spread over a given calendar date). Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient. For each medical encounter, the physician's progress notes must document the total time that critical care services are provided.

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For Medicare Part B physician services, paid under the physician fee schedule, critical care is not a service that is paid on a “shift” basis or a “per day” basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include:

- Claims from several physicians submitting multiple units of critical care for a single patient; and
- Submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date.

Physicians assigned to a critical care unit (e.g., hospitalist, intensivist etc.) may not report critical care for patients based on a “per shift” basis. You should use CPT code 99291 (evaluation and management of the critically ill or critically injured patient, first 30-74 minutes) to report the first 30-74 minutes of critical care on a given calendar date of service. You can only use this code once per calendar date to bill for care provided for a particular patient by the same physician or physician group of the same specialty.

CPT code 99292 (critical care, each additional 30 minutes) is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care. Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

Table 1 (below) illustrates the correct reporting of critical care services, followed by a clinical example.

Table 1
Reporting of Critical Care Services

Total Duration of Critical Care	Appropriate CPT Codes
Less than 30 minutes	99232 or 99233 or other appropriate E/M code
30 - 74 minutes	99291 x 1
75 - 104 minutes	99291 x 1 and 99292 x 1
105 - 134 minutes	99291 x1 and 99292 x 2
135 - 164 minutes	99291 x 1 and 99292 x 3
165 - 194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291 – 99292 as appropriate (per the above illustrations)

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Clinical Example of Correct Billing of Time:

A patient arrives in the emergency department (ED) in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the CCU. In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (CPT code 99291) and not also codes for emergency department services. Using CPT code 99291, the cardiologist may also report the 35 minutes of critical care services provided in the ED. Additional critical care services by the cardiologist in the CCU (on the same calendar date) using 99292 or another appropriate E/M code depending on the clock time involved.

Other Critical Care Issues

There are some specific rules about physician services and time that you should know:

1. Only one physician can bill for critical care during any one single period of time. Unlike other E/M services, critical care services reflect one physician's (or qualified non-physician practitioner's) care and management of a critically ill or critically injured patient for the specified reportable period of time. You cannot report a split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) as a critical care service. The critical care service reported should reflect the evaluation, treatment and management of the patient by the individual physician or qualified non-physician practitioner and not representative of a combined service between a physician and a qualified NPP.

When CPT code requirements for time and critical care requirements are met for a medically necessary visit by a qualified NPP, the service shall be billed using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services.

Please note that medically necessary service(s) that do not meet critical care criteria may be reported as subsequent hospital care services.

In denying a claim for a critical care service that is a split/shared service, carriers and A/B MACS will use the following messages:

Claims Adjustment Reason Code:

150 – Payment adjusted because the payer deems the information submitted does not support this level of service.

Remittance Advice Reason Code:

N180 – This item or service does not meet the criteria for the category under which it was billed.

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17.11 – This item or service cannot be paid as billed.

For unassigned claims, Medicare contractors will use add-on message 16.34 – You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'you may be billed' column; or

For assigned claims, Medicare contractors will use add-on message 16.35 – You do not have to pay this amount.

2. When performed on the day a physician bills for critical care, the following services are included in the critical care service, and should not be reported separately:

- the interpretation of cardiac output measurements (CPT 93561, 93562)
- chest x-rays, professional component (CPT 71010, 71015, 71020)
- blood draw for specimen (CPT 36415)
- blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data (CPT 99090))
- gastric intubation (CPT 43752, 91105)
- pulse oximetry (CPT 94760, 94761, 94762)
- temporary transcutaneous pacing (CPT 92953)
- ventilator management (CPT 94002 – 94004, 94660, 94662)
- vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)

No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

3. Concurrent care by more than one physician (generally representing different physician specialties) is payable if the services all meet critical care requirements, are medically necessary, and are not duplicative (refer to *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 30 (Physician Services) for concurrent care policy discussion).

Critically ill or injured patients may require the care of more than one physician medical specialty, but keep in mind that the critical care services provided by each physician must be medically necessary. Medicare will pay for non-duplicative, medically necessary critical care services provided by 1) physicians from the same group practice; or 2) from different group practices to the same patient.

Note: Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the Medicare contractor who adjudicates the claims. Physicians in the same group

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practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative the critical care services may be reported by each regardless of their group practice relationship.

Your medical record documentation must support that the critical care services each physician provided were necessary for treating and managing the patient's critical illness(es) or critical injury(ies). Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), and Section 40 (Surgeons and Global Surgery); and *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), and Section 30 (Physician Services)).

You will need to follow these specific coding requirements.

- The initial critical care time (billed as CPT code 99291) must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical examination performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.
- Subsequent critical care visits performed on the same calendar date are reported using CPT code 99292. The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.
- Physicians in the same group practice who have the same specialty may not each report CPT initial critical care code 99291 for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners).)
- Physicians in the same group practice, with different specialties, who provide critical care to a critically ill or critically injured patient may not

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always each report the initial critical care code (CPT 99291) on the same date. When these physicians are providing care that is unique to his/her individual medical specialty, and are managing at least one of the patient's critical illness(es) or critical injury(ies); then the initial critical care service may be payable to each. However, if a physician (or qualified NPP) within a group provides "staff coverage" or "follow-up" for each other after another group physician provided the first hour of critical care services on that same calendar date but has left the case; the second group physician (or qualified NPP) should report the CPT critical care add-on code 99292, or another appropriate E/M code.

Clinical Examples of Critical Care Services

- a) Two pulmonary specialists, who share a group practice, each provide critical care services (at different times during the same day) to a patient who has multiple organ dysfunction (including cerebral hematoma, flail chest and pulmonary contusion), is comatose, and has been in the intensive care unit for 4 days following a motor vehicle accident. Both physicians may report medically necessary critical care services provided at the different time periods. One physician would report CPT code 99291 for the initial visit and the second, as part of the same group practice, would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.
- b) A 79 year old male comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates him and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the ER and admits him to the observation unit for monitoring, and diagnostic and laboratory tests; during which time he has a cardiac arrest. His primary care physician provides 50 minutes of critical care services, and admits him to the intensive care unit. On the same calendar day his condition deteriorates and he requires intermittent critical care services. In this scenario, the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

4. When a patient requires critical care services upon presentation to a hospital emergency department, you may only report critical care codes 99291 - 99292. You may not also report an emergency department visit code. However, when critical care services are provided on a day during which an inpatient hospital, or office/outpatient evaluation and management service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous evaluation and management service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when

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provided by the same physician to the same patient. Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other evaluation and management services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

5. Critical care services will not be paid on the same calendar date that the physician also reports a procedure code with a global surgical period, unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable, evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (CPT code 93503) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, should be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10, or 90 day global period including cardiopulmonary resuscitation (CPR -- CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing CPR should be excluded from the determination of the time spent providing critical care. In this instance the physician who performs the resuscitation must bill for this service. Members of a code team cannot each bill Medicare Part B for this service.

When a physician, other than the surgeon, provides postoperative critical care services (for procedures with a global surgical period); no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, both the surgeon and intensivist, who are submitting claim, must use CPT modifiers "-54" (surgical care only) and "-55" (postoperative management only). Critical care services must meet all the conditions previously described, and the medical record documentation of the surgeon and physician who assumes a transfer (e.g., intensivist's), must both support claims for services when CPT modifiers -54 and -55 are used indicating the transfer of care from the surgeon to the intensivist.

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6. In addition to a global fee, critical care services provided during the preoperative portion and postoperative portions of the global period of procedures with 90 day global period in trauma and burn cases may be paid if the patient is critically ill and requires the full attention of the physician; and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed.

Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life threatening deterioration in the patient's condition. Preoperatively, in order for these services to be paid, two reporting requirements must be met. Codes 99291 - 99292 and modifier -25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Postoperatively, in order for these services to be paid, two reporting requirements must also be met. Codes 99291 - 99292 and modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.

An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Note: Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

7. Critical care CPT codes 99291 and 99292 include pre and post service work. Routine daily updates or reports to family members and or surrogates are considered part of this service.

However, time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in CPT), may be counted toward critical care time when these specific criteria are met:

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- The patient is unable or incompetent to participate in giving a history and/or making treatment decisions; and
- The discussion is necessary for determining treatment decisions.

For such family discussions, the physician should document:

- The medically necessary treatment decisions for which the discussion was needed;
- That the patient is unable or incompetent to participate in giving history and/or making treatment decisions;
- The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family"; and
- A summary in the medical record that supports this medical necessity.

Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, only if they meet the same criteria as described in the aforementioned paragraph. Further, no other family discussions (no matter how lengthy) may be additionally counted towards critical care.

8. A teaching physician, to bill for critical care services, must meet the requirements for critical care described above. For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.4 (Time-Based Codes).

Time spent teaching may not be counted towards critical care time. Nor, can the teaching physician bill, as critical care or other time-based services, for time spent by the resident (in the teaching physician's absence). Only time that the teaching physician spends alone with the patient (and that he/she and the resident spend together with the patient), can be counted toward critical care time.

A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment.

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However, the teaching physician medical record documentation must provide substantive information including:

- Time the teaching physician spent providing critical care;
- That the patient was critically ill during the time the teaching physician saw the patient;
- What made the patient critically ill; and
- The nature of the treatment and management provided by the teaching physician.

The medical review criteria are the same for the teaching physician as for all physicians. (See *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.1 (Evaluation and Management (E/M) Services) for teaching physician documentation guidance).

The following is an example of acceptable teaching physician documentation: *"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."* Conversely, the following is an example of unacceptable documentation from a teaching physician: *"I came and saw (the patient) and agree with (the resident)"*.

9. Medicare recognizes ventilator codes (CPT codes 94002 - 94004, 94660 and 94662) as physician services payable under the physician fee schedule. Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an E/M service (e.g., critical care services, CPT codes 99291 - 99292) on the same day for the patient even when the E/M service is billed with CPT modifier -25.

Additional Information

You can find more information about critical care visits and neonatal intensive care (codes 99291 - 99292) by going to CR 5993, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1548CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. Updated *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.12. (Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292) is an attachment to that CR.

If you have any questions, please contact your carrier at their toll-free number, which may be found at

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<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>
on the CMS website.

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