Irish Life health

Intensive Care Medicine

Ground Rules

In-patient Attendance and Other Medical Services
Intensivist and Anaesthetist

2025

1. Consultation Benefit for Intensive Care Unit

Consultation benefit is payable to the consultant intensivist attached to an Irish Life Health approved Intensive Care Unit (ICU) for a patient being assessed for admission to the ICU as defined in Intensive Care Medicine and where it is deemed that the patient does not require admission to the ICU.

This consultation includes:

- A full history and examination of all systems
- Evaluation of appropriate diagnostic tests
- Formal symptom assessment
- Providing an opinion and/ or diagnosis and making an appropriate recording of same

The duration of this consultation must be a minimum of 30 minutes and reason stated with the claim submitted.

2. Conditions of payment

The claiming benefit will continue on the basis of a fully completed Irish Life Health claim form from the primary treating Consultant.

3. Intensive Care Medicine Benefit

The Intensive Care benefits are only payable to Consultant intensivists who are registered with Irish Life Health and where the Consultant is registered on the Medical Council of Ireland and/ or Intensive Care Medicine Division or a Consultant with regular ongoing scheduled exclusive commitments to Intensive Care Medicine who is registered on the Anaesthesia, Intensive Care Medicine and Pain Medicine specialist register.

These benefits relate to the Intensive Care management of appropriately admitted patients to an Irish Life Health approved Intensive Care Unit (ICU) where the patient has been admitted under the care of the appropriately qualified Consultant intensivist* or the critical care of the patient has been transferred to the Consultant intensivist by another hospital Consultant. The benefits do not apply to the admitting Consultant nor are they payable in addition to the benefit for a consultation.

In non-surgical cases when the patient has been admitted under the care of a Consultant physician and requires active medical attention from the admitting physician during their stay in the ICU, the in-patient attendance benefit is payable to the admitting physician and the Intensive Care benefit is payable to the Consultant intensivist who treats the patient in the ICU.

**Consultant intensivist refers to the Consultant(s) who takes responsibility for the patient during their stay in the ICU and who are members of the Joint Faculty of Intensive Care Medicine of Ireland.*

4. Intensive Care Unit Approval

An Irish Life Health approved ICU must be a separate designated hospital facility for the care of the critically ill patient. It must be equipped and staffed appropriately to be able to support common single and multi-organ system failures.

Each ICU bed space must be able to provide:

- Continuous ECG display and heart monitoring
- Continuous invasive and non-invasive haemodynamic monitoring
- Continuous central venous and/ or pulmonary arterial pressure monitoring
- Continuous mechanical ventilation and oxygen monitoring, including ventilator disconnection and parameter alarms
- Continuous inspired oxygen concentration monitoring and end-tidal capnography
- Continuous central and/ or cutaneous temperature measurement
- Cardiac output monitoring and measurement
- Oxygen supply failure alarm
- Access to arterial blood gas monitoring
- Continuous Renal Replacement Therapy

There must also be access to 24-hour laboratory service orientated to Intensive Care service units.

5. Intensive Care Medicine Services

The Intensive Care Medicine benefit is payable for the care of a patient appropriately admitted to an Irish Life Health approved ICU . The Intensive Care Unit (ICU) provides the highest level of care for critically ill patients who require intensive monitoring, life-sustaining treatments, and advanced organ support. This includes patients with severe or unstable conditions needing interventions such as mechanical ventilation, vasopressor support, or continuous renal replacement therapy.The following criteria determines the appropriateness and need for a patient's admission to and ongoing treatment within the ICU:

ICU Admission Criteria (ABCDE Framework)

A – Airway

Admission to the ICU is warranted when a patient has an actual or imminent threat to the airway that cannot be managed in a general ward or high-dependency unit. This includes cases where the patient cannot protect their airway due to reduced consciousness,

anatomical compromise, or the need for endotracheal intubation and mechanical airway control.

Indications for ICU admission include:

- Actual or impending airway obstruction
- Need for advanced airway management (e.g., endotracheal intubation, tracheostomy)
- Inability to protect airway (e.g., decreased level of consciousness, excessive secretions)

Examples:

- Severe facial or neck trauma and burns
- Angioedema with airway compromise
- Airway tumors or bleeding causing airway obstruction (e.g., laryngeal or tracheal malignancy)
- Any patient requiring mechanical ventilation
- Decreased level of consciousness from any cause with inability to protect airway

B – Breathing

Patients should be admitted to the ICU if they present with severe or worsening respiratory failure that requires invasive mechanical ventilation, advanced respiratory support, or continuous monitoring unavailable in lower levels of care. This includes persistent hypoxaemia (e.g., PaO_2 < 8.0 kPa) despite oxygen therapy or hypercapnic respiratory acidosis unresponsive to oxygen therapy and non-invasive ventilatory support.

Indications for ICU admission include:

- Acute or impending severe respiratory failure with high likelyhood of requiring mechanical invasive ventilatory support
- Severe hypoxia (e.g., PaO_2 < 8 kPa) or hypercapnia not resp onding to treatment with supplemental oxygen or non-invasive ventilatory support
- Need for invasive mechanical ventilation

Examples:

- - Severe pneumonia or acute respiratory distress syndrome (ARDS) with severe respiratory failure
- Status asthmaticus not responding to initial treatment
- Massive pulmonary embolism with respiratory failure
- Any condition requiring invasive mechanical ventilation (including post-operative care)

C – Circulation

ICU care is indicated for patients with hemodynamic instability unresponsive to initial resuscitation, requiring continuous administration of vasoactive drugs (e.g., vasopressors or inotropes), shock states, recurring life-threatening arrhythmias, or massive hemorrhage.

Indications for ICU admission include:

- \- Hemodynamic instability or shock (e.g., systolic BP < 90 mmHg, MAP < 65 mmHg) not responding to initialt therapies
- Circulatory failure or any cause requiring vasopressors or inotropic support
- Active major bleeding requiring ongoing b lood transfusions and intensive monitoring for hemodynamic instability or further deterioration
- Post-cardiac arrest care requiring cardiovascular and neurological support

Examples:

- Septic shock requiring vasopressors or inotropic support
- Acute myocardial infarction with cardiogenic shock
- Major bleeding from any cause with hemodynamic instability
- Postoperative circulatory instability requiring vasopressor or inotropic support, invasive monitoring, and close hemodynamic observation in the ICU setting.

D – Disability (Neurological)

ICU-level care is required for patients with altered mental status at risk of airway loss, uncontrolled seizures, or raised intracranial pressure. Close neurological observation and possible mechanical ventilation are necessary for conditions that may rapidly progress to respiratory or multi-organ failure.

Indications for ICU admission include:

- Altered level of consciousness (e.g., GCS < 8) that is not rapidly reversible
- Status epilepticus and prolonged seizures
- Acute stroke with compromised airway or hemodynamic instability
- Intracranial hemorrhage or other lesions with increased intracranial pressure
- Acute neuromuscular diseases with respiratory failure or hemodynamic instability

Examples:

- Traumatic brain injury or stroke with reduced GCS
- Drug overdose with respiratory or neurological compromise
- Unconscious patients of any cause requiring close monitoring for airway compromise or respiratory failure

E – Exposure / Other Critical Conditions

Patients with multisystem illness, complex post-operative complications, or high-risk metabolic conditions require ICU admission when continuous monitoring, rapid intervention, or multi-organ support is needed. These conditions exceed the capabilities of a general ward or HDU and present a high risk of rapid deterioration.

Indications for ICU admission include:

- Severe tramatic injuries or multisystem trauma
- Extensive burns (>15-20% TBSA)
- Post-major surgery requiring intensive monitoring
- Severe life-threatening electrolyte, metabolic or endocrine derangements
- Acute renal failure requiring continuous renal replacement therapy
- Complicated obstetric emergencies (e.g., eclampsia, postpartum hemorrhage)
- Severe multi-organ failure
- Specific treatments/procedures not available outside an ICU such as intra-aortic balloon pump (IABP) management, extracorporeal membrane oxygenation (ECMO) and intracranial pressure (ICP) monitoring

Examples:

- Major trauma
- Major surgery with circulatory, respiratory or neurological compromise
- Fulminant hepatic failure with circulatory, respiratory or neurological compromise
- Acute poisoning with unstable vitals (cardiovascular, respiratory or neurological compromise)
- Initialt post-operative care for major surgery

Additional Considerations for ICU Admission:

Patients who should not be admitted to the ICU are those for whom intensive care would not provide meaningful benefit. This includes individuals wi th irreversible conditions where ICU-level interventions would not alter the outcome, such as patients in the terminal phase of a chronic illness or comfort-care-only orders, or those with poor prognosis despite maximal therapy. ICU admission is generally inappropriate when it is inconsistent with the patient's goals of care or when the burdens of treatment outweigh the potential benefits.

Patient care in ICU includes but is not limited to the following:

- Regular assessment of the patient including blood gases and/ or pulmonary function testing
- Minute by minute attendance with the patient with frequent re-assessment of clinical state and frequent review by the Consultant Intensivist during each 24-hour period
- Continuous Renal Replacement Therapy (CRRT)
- Single or multi-organ support
- Prescription of appropriate sedative/ analgesic regimes, including narcotic infusions
- Intravenous drug administration including infusions
- Central venous access device placement
- Vaso-active agents
- Venous pressure and blood volume studies
- Nasogastric tube placement and monitoring
- Total parenteral nutrition
- Trans-tracheal aspiration
- Laryngoscopy
- Endotracheal intubation including induction of general anaesthesia
- Invasive neurological monitoring
- Invasive cardiac assessment and monitoring
- Performance and interpretation of other tests and procedures, as appropriate

A High Dependency Unit (HDU) provides an intermediate level of care between the general ward and the Intensive Care Unit (ICU). It is suitable for patients who are clinically stable but at risk of deterioration, or who require closer monitoring and limited organ support than what can be safely delivered on a general ward, but do not require full intensive care. The HDU may also be used for step-down care from the ICU.

The following criteria determines the appropriateness and need for a patient's admission to and ongoing treatment within the HDU:

HDU Admission Criteria (ABCDE Framework)

A – Airway

Indications: HDU admission is appropriate for patients with a stable airway who are at risk of deterioration and require frequent (hourly) observation or basic airway interventions. These patients do not require invasive ventilation, but may need support beyond what can be provided on the ward.

Common scenarios for HDU admission include:

- Post-extubation monitoring in patients at risk of re-intubation or airway obstruction
- Patients with airway edema or swelling needing close observation
- Facial or neck swelling fo llowing surgery or infection

B – Breathing

Indications: HDU care is suitable for patients with moderate respiratory failure who need non-invasive ventilatory support or high-flow oxygen therapy, and ongoing respiratory monitoring, but who do not require invasive mechanical ventilation or ICU-level support.

Common scenarios for HDU admission include:

- Respiratory failure requiring non-invasive ventilation (e.g., CPAP or BiPAP) or high-flow oxygen therapy (FiO_2 > 40%)
- Close respiratory observation in patients recently stepped down from ICU
- Respiratory failure not requiring intubation but close monitoring (hourely) and treatment
- Post-surgery with high risk of respiratory compromise

C – Circulation

Indications: HDU admission is warranted for patients with circulatory instability or fluid imbalance that exceeds ward-level care, but who do not require continuous vasopressor support or invasive monitoring as in ICU. These patients often need frequent assessments (hourly), advanced f luid/electrolyte management, and possibly low-dose pharmacological support.

Common scenarios for HDU admission include:

- Post-surgical patients requiring close (hourly) observation for bleeding or hypotension
- Septic patients responding to fluid resuscitation without signs of septic shock
- Life-threatening arrhythmias needing continuous ECG monitoring and rapid access to advanced cardiac life support
- Post-major surgery with high risk for hemodynamic compromise
- Patient's requiring treatment with single-agent low-dose vasopressors for moderate circulatory failure (if allowed by local protocols)

D – Disability (Neurological)

Indications: HDU is suitable for patients with altered mental status or neurological conditions that require frequent monitoring (hourly), but who do not need airway protection or ICU-level support.

Common scenarios for HDU admission include:

- Neurological disease requiring regular (hourly) GCS monitoring
- Recent seizures or drug overdoses requiring freque nt monitoring but not ICU care
- Delirium requiring close observation (hourly)
- Major head injury without signs of rapid neurological deterioration
- Acute neuromuscular diseases with high risk of respiratory failure or hemodynamic instability

E – Exposure / Other Critical Conditions

Indications: HDU care is appropriate for patients with complex conditions requiring frequent clinical assessments (hourly), intensive/advanced treatment, or interventions not feasible on the ward, but who are not critically unstable. This includes step-down care from ICU and high-risk post-operative monitoring.

Common scenarios for HDU admission include:

- Step-down care for patients recovering from sepsis or surgery
- High-risk post-operative care in patients with significant comorbidities
- Metabolic or infectious disorders requiring close observation and advanced pharmacological treatment
- Post-major surgery with increased monitoring needs due to high risk for airway compromise, respiratory failure or hemodynamic instability
- Severe infections requiring close monitoring and treatment but not multi-organ support

A Coronary Care Unit (CCU) is a specialized unit within a hospital designed for the monitoring, treatment, and management of patients with serious or potentially life-threatening cardiovascular conditions. It offers continuous ECG monitoring, rapid access to advanced cardiac life support, and specialized nursing and medical care for acute cardiac illnesses.

The following criteria determines the appropriateness and need for a patient's admission to and ongoing treatment within the CCU:

CCU Admission Criteria:

1. **Acute Coronary Syndromes (ACS)**

> ST-Elevation Myocardial Infarction (STEMI) – preand post-reperfusion therapy (e.g., PCI, thrombolysis)
> Non-ST Elevation Myocardial Infarction (NSTEMI)
> Dynamic ECG changes or elevated troponins in patients with suspected ACS
> Hemodynamic or arrhythmic instability caused by coronary disease
> Unstable angina with high-risk features (e.g., ongoing chest pain, ECG changes)

2. **Life-Threatening Arrhythmias**

> Ventricular arrythmias including ventricular tachycardia (VT) or ventricular fibrillation (VF)
> High-grade atrioventricular (AV) block (e.g., Mobitz type II, com plete heart block)
> Symptomatic bradyarrhythmias
> Supraventricular arrhythmias (e.g., atrial fibrillation/flutter) with: hemodynamic compromise or rapid ventricular rates unresponsive to initial treatment

3. **Acute Heart Failure**

> Acute decompensated heart failure with: pulmonary edema, significant hypoxia, need for non-invasive ventilation or hemodynamic instability

4. **Post-Cardiac Arrest Care**

> Patients who have achieved return of spontaneous circulation (ROSC) following a cardiac arrest, where: continuous cardiac monitoring is required but without altered level of consciousness or multi-organ failure.

5. **Post-Interventional Cardiac Procedures**

> Post-percutaneous coronary intervention (PCI) in high-risk patients (e.g., complex lesions, poor LV function)
> Post-pacemaker or implantable cardioverter-defibrillator (ICD) insertion in patients with high risk of arrhythmia or hemodynamic instability
> Post-electrophysiology studies or ablation procedures with high risk of arrhythmia or hemodynamic instability

6. **Hypertensive Emergencies with cardiac involvement such as acute pulmonary edema, cardiac ischemia or arrhythmias**

7. **Myocarditis or Pericarditis**

> Suspected or confirmed myocarditis with: ECG changes or elevated troponins

> Hemodynamic impact (e.g., pericardial effusion, tamponade physiology or cardiac failure)

8. **Severe Electrolyte or Metabolic Disturbances with Cardiac Risk**

> Electrolyte imbalances with arrhythmogenic potential: severe hyperkalemia, hypokalemia, hypocalcemia, or hypomagnesemia

> Drug-induced cardiotoxicity with high risk for arrhythmias or cardiac failure

9. **High-Risk Syncope or Unexplained Collapse**

> Syncope of suspected cardiac origin, especially if abnormal ECG, structural heart disease or suspected ventricular arrhythmias

6. Eligibility for Intensive Care Services

If a patient requires unplanned admission arising from a medical or post-operative emergency, ICU benefit will be considered on submission of details and supplementary claim form to Irish Life Health. The duration of ventilator support shall be calculated from the time of admission to the ICU.

If a patient is not extubated post-operatively, an ICU benefit is only payable where there is a clinically sound rationale for continued mechanical ventilation.

If a patient requires post-operative care in the ICU setting by virtue of the complexity of surgery and/ or underlying co-morbidities, but where they do not require organ supports, reimbursement at the standard in-patient rate will be made where the admission is in line with national standard practice and where the Consultant intensivist has demonstrated contribution in the patient's care.

7. Clinical Standards in the Intensive Care Unit

Each ICU unit must fully comply with standards in relation to:

1. Medical staff
2. Nursing protocols
3. Clinical protocols

4. Quality assurance
5. Training and continuing education

Medical Staff in ICU

The ICU should be staffed with consultants whose principal duties are to the ICU. The ICU must have a rostered consultant intensivist available to the ICU 24 hours a day, seven days a week.

The rostered consultant intensivist must be exclusively available to the ICU during their allocated shift. They must not have other commitments during that time. There must be a designated consultant intensivist as Medical Director of the ICU.

Non-consultant doctors must be made available exclusively to the ICU and provide immediate cover to the ICU 24 hours a day seven days a week. The Medical Director must be satisfied that these non-consultant doctors are suitably qualified for this role.

Nursing Protocols

All units undertaking intensive care should be able to demonstrate the required number of appropriately qualified and trained nurses. All units should also have a designated nurse lead with ICU experience and managerial responsibility allocated per shift.

All units should have a designated nurse (clinical facilitator) who is responsible for the further education and training of staff, including in-service education and experience of resuscitation of the critically ill patient.

All invasive mechanically ventilated patients and other similarly critically ill patients must be nursed in a 1:1 or 1:2 ratio by suitably qualified registered nurses. 50% of the nurses in the ICU should have worked in the ICU setting for greater than two years or should have post-registration qualification in intensive care attained to graduate certificate level as a minimum. The nurse in charge of the unit must have a post-registration qualification in intensive care. At least two registered nurses must always be present in the unit.

The need for extra nursing support cannot be predicted so there should always be at least one nurse available on each shift to provide ICU care if required.

The nursing establishment of each ICU should be sufficient to allow for leave, maternity cover, sickness, study leave, staff training and professional development without compromising the principles outlined above.

Clinical Protocols, Quality Assurance and Training

All units undertaking intensive care should agree written protocols for medical and nursing staff which should also contain details around practical procedures. These must be reviewed regularly through discussion and audit.

There should be a protocol for the resuscitation and management of critically ill patients. There should be monitoring systems for short- and long-term morbidity among patients, with plans for regular review.

All new staff members must undergo a period of introduction, orientation, and training. All hospitals providing intensive care service should have a regular continuous programme of in-service training. Nurses and doctors involved in intensive care should be able to demonstrate continuing professional development in the speciality by attending regular multi-disciplinary meetings, local meetings, training courses and national meetings/ conferences.

The unit should use a data collection system to monitor workload and the results of practice. Each unit should also have a written policy in relation to an established strategy for clinical governance, maintenance, upgrading and replacement of equipment, which should comply with national standards. This should also include an auditing programme and critical incident reporting system. Clinical audit must be a component of Intensive Care Medicine service and the anonymised data should be available to Irish Life Health on an annual basis.

8. Fee rate and additional codes that can be billed

Daily Fee

The following is the daily fee rate payment for all services provided by a Consultant intensivist and care provided within a listed ICU:

Code	Description
10034	Anaesthesia - ICU in-patient medicine benefit - 1 night stay
10035	Anaesthesia - ICU in-patient medicine benefit - 2 night stay
10036	Anaesthesia - ICU in-patient medicine benefit - 3 night stay
10037	Anaesthesia - ICU in-patient medicine benefit - 4 night stay
10038	Anaesthesia - ICU in-patient medicine benefit - 5 night stay
10039	Anaesthesia - ICU in-patient medicine benefit - 6 night stay
10040	Anaesthesia - ICU in-patient medicine benefit - 7 night stay
10041	Anaesthesia - ICU in-patient medicine benefit - 8 night stay
10042	Anaesthesia - ICU in-patient medicine benefit - 9 night stay
10043	Anaesthesia - ICU in-patient medicine benefit - 10 night stay
10044	Anaesthesia - ICU in-patient medicine benefit - 11 night stay
10045	Anaesthesia - ICU in-patient medicine benefit - 12 night stay
10046	Anaesthesia - ICU in-patient medicine benefit - 13 night stay
10047	Anaesthesia - ICU in-patient medicine benefit - 14 night stay
10048	Anaesthesia - ICU in-patient medicine benefit - 15 night stay

10069	Anaesthesia - ICU in-patient medicine benefit - per night after night 15 of stay

Benefit for the following medical services and procedures can be billed in addition to the ICU medicine benefit and can only be paid once during the patients stay in ICU:

Code	Description
5921	Tracheostomy, permanent
5091	Cardioversion
5109	Echocardiography, transoesophageal (TOE)
5952	Insertion of tube drain in pleural cavity
5065	Insertion or replacement of temporary transvenous single chamber cardiac electrode
195859	Placement of second non tunnelled central venous catheter in ICU by a qualified ICU intensivist

To qualify as a central venous access catheter or device, the tip of the catheter/ device must terminate in either the subclavian, brachiocephalic or iliac veins, the superior or inferior vena cava, or the right atrium. The venous access device may be either centrally inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or peripherally inserted (basilica or cephalic vein). The device must be accessed for use either via exposed catheter, via a subcutaneous port or via a subcutaneous pump.

Benefit for the following medical procedures can be billed in addition to the ICU medicine benefit during the patients stay in ICU:

Code	Description
837	Continuous veno-venous haemofiltration or dialysis (CVVH/CVVHD) in a critically ill patient, per day
1994	Bronchoscopy; diagnostic, flexible with or without one of the following: (a) bronchoalveolar lavage, (b) cell washing or brushing, (c) bronchial biopsy (I.P.)

9. One Night Rule

In accordance with the rules governing payments made to Consultant anaesthesiologists for the attendance and treatment of Irish Life Health members to include (but not limited to) pre-, peri- and post-operative care (as per the Anaesthesia Ground Rules), where the anaesthesiologist performed the above function, they will not be entitled to claim for payment for the first night of ICU admission and treatment. The payment for ICU attendance by the operation/ procedure anaesthesiologist will only commence when the member completes the first 24-hour period of ICU attendance (i.e. day two) and payment will be set to the day one rate of ICU benefit.

Where the anaesthesiologist is part of an anaesthesiologist / intensivist group, this will also apply to that individual anaesthesiologist in the group practice. It is therefore required that the group member billing for anaesthetic and/ or ICU services identify themselves on invoice.

Where the clinical care of a post-operative patient is handed over on admission to ICU to the duty intensivist (who is delivering a separate and distinct ICU service whereby the intensivist is wholly and exclusively delivering ICU care without concomitant anaesthesia commitments) the ICU fees payable will commence from time of admission to ICU.

10. Current Irish Life Health List of ICU beds

County	Hospital Name	Beds
Cavan	Cavan General Hospital	2
Cork	Mercy Hospital	5
	Bon Secours Hospital System - Cork	6*
	Cork University Hospital	19
Donegal	Letterkenny General Hospital	5
Dublin	Tallaght University Hospital	13
	Beacon Hospital	8
	Beaumont Hospital	23
	Blackrock Clinic	12
	Connolly Hospital Blanchardstown	4
	Hermitage Medical Clinic	6*
	Mater Misericordiae University Hospital	17
	Mater Private Hospital	9
	St. James's Hospital	31
	St. Vincent's University Hospital Elm Park	10
Galway	Galway Clinic	8
	Portiuncula Hospital Ballinasloe	4
	University Hospital Galway	15
Kerry	Kerry University Hospital	5
	Bon Secours Hospital System - Tralee	1*

Kildare	Naas General Hospital	4
Kilkenny	St. Luke's General Hospital	4
Laois	Midland Regional Hospital, Portlaoise	2*
Limerick	University Hospital Limerick	12
Louth	Our Lady of Lourdes Hospital Drogheda	6
Meath	Navan Hospital	2
Mayo	Mayo University Hospital Castlebar	3
Offaly	Midland Regional Hospital Tullamore	5
Sligo	General Hospital Sligo	5
Tipperary	South Tipperary Hospital (Clonmel)	4
Waterford	Waterford Regional Hospital	6
Westmeath	Midlands Regional Hospital (Mullingar)	2
Wexford	Wexford General Hospital	5

Note 1: The consultant intensivist is most welcome to make recommendations to Irish Life Health on this matter at provider.services@irishlifehealth.ie

Appendix 1 – Level of Critical Care

Care Type	Level	Description
Acute Care	Level 0	Hospital ward clinical management
	Level 1	Higher level of observation eg. PACU
Critical Care	Level 2	Active management by critical care team to treat and support critically ill patients with primarily single organ failure
	Level 3	Active management by critical care team to treat and support critically ill patients with two or more organ failures
	Level 3s	Level 3 with regional / national service

Level	Description
Level 0	Patient whose needs can be met through normal ward care in an acute hospital
Level 1	Patient at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team
Level 2	Patients requiring more detailed observation or intervention including support for a single failing organ, post operative care and those 'stepping down' from higher levels of care
Level 3	Patients requiring advanced respiratory support alone or basic respiratory support together with support for at least two organ systems. This level includes all complex patients requiring support for multi-organ failure

Appendix 2 – Consultant Discharge letter to accompany each claim

A comprehensive contemporaneous consultant ICU discharge letter must be submitted with each claim. The information provided in this will form the basis for assessment of both the clinicians and hospital claim.

A discharge letter should include at a minimum the following information:

- **a.** Date and time of admission
- **b.** Date and time of discharge
- **c.** Specific Reason for admission to ICU
- **d.** Describe organ failures and organ supports delivered
- **e.** Date and time of ventilatory support commencement and cessation, including invasive and non-invasive
- **f.** Describe any specific procedures performed
- **g.** Detailed description of clinical support provided
- **h.** Outline any follow up care required

Irish Life health

Irish Life Health, P.O. Box 13028, Dublin 1.
Irish Life Health dac is regulated by the Central Bank of Ireland.
Terms and Conditions apply. Registered in Ireland No. 376607.
Registered Office: Irish Life Centre, Lower Abbey Street, Dublin 1

ILH_10164-25-06