Priority Health	BILLING POLICY No. 006
CRITICAL CARE SERVICES	
Date of origin: Sept. 2024	**Review dates: 2/2025, 8/2025, 4/2026, 7/2026**

DEFINITION

Critical care is defined as direct care delivery to a critically ill or critically injured patient having one or more vital organ systems that are acutely impaired. There's a probability of life-threatening deterioration due to the patient's current condition. The complexity of care to treat the member is high due to single or multiple vital organ failures or the need to prevent further deterioration of member's condition, which requires the practitioner's full attention. Due to the possibility of multiple systems impacted by member's condition, concurrent critical care may exist with multiple specialties.

Hospital Evaluation and Management (E/M) services may be coded separately on the same date of service as long documentation supports the services were performed (significant and separately identifiable from critical care) **before** critical care services begin. The appropriate modifier should be appended to reflect a significant, separately identifiable service.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual

POLICY SPECIFIC INFORMATION

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Coding specifics

Critical care services are reported CPT codes below:

Code	Description
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger

99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

As defined by AMA coding guidelines, CPT 99291 should be coded as a primary service. Critical care services require the provider to be directly involved with the member's care and treatment plan due to the complexity of evaluating, controlling and supporting the vital system functions for stabilization and decline.

Critical care is time-based and shouldn't be coded for less than 30 minutes.

- Although a member may be admitted into a critical care unit, this doesn't drive coding as critical care services.
- Time must be documented in the medical record. Failure to document time will result in a claim denial.
- Critical care code 99291 is reported per encounter of critical care. If this time is continuous into the next day, the date of service should be the calendar date when the encounter started.
- Critical care services time is based on the time spent caring for the critically ill or injured member while on the floor or unit. Although time doesn't need to be contiguous, only time spent bedside in direct patient care or time spent on the member's floor directly assessing or associated with that member's care is counted in total time. Time spent with other patients wouldn't be counted in total time.
- Critical care service add on code 99292 may be reported without the primary code 99291 when performed by another physician in the same group practice associated with call coverage.
- Code selection should be aligned to the member's age for accurate coding.

Critical care services include the following:

- Interpretation of cardiac output measurements
- Chest x-rays
- Pulse oximetry
- Blood gases
- Review of data stored in computers/electronic records
- Gastric intubation
- Temporarily transcutaneous pacing
- Ventilatory management
- Vascular access procedures

Critical care services can be furnished as shared or split visits. See additional information on shared or split billing.

Critical care services reported on the same date as a discharge service will result in a claim denial. This doesn't include transfers to another facility or if member expires.

Modifiers

- FS modifier should be appended to these shared or split services. See additional information on shared or split billing.

- FT modifier should be appended to the critical care service to reflect an unrelated service. This must be supported within the medical record.

RESOURCES

- MLN906764_Evaluation_and_Management_Services_Guide_2023-08 (cms.gov)
- E/M: Service-Specific Coding: Critical Care (novitas-solutions.com)
- MM12550 - Internet-Only Manual Updates for Critical Care Evaluation and Management Services (cms.gov)

RELATED POLICIES

- Split Billing

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 4, 2025	Added “Disclaimer” section
Aug. 25, 2025	Removed: Medical records can be submitted via appeal if extenuating circumstances exist for a same-day discharge of members who received critical care services.
April 20, 2026	Reviewed- no changes
July 2026	Format updates only.