

	Critical Care Services	
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PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROFESSIONAL	FACILITY	DME	AMBULATORY SURGERY	LAB	OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMERCIAL	BLUE MEDICARE ADVANTAGE	ACA QHP¹	SMALL GROUP ACA	JAA²	FEP³	DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

CPT/CMS currently defines a critical illness or injury as an illness or injury that 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 services include but are not limited to, the treatment or prevention or further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, post-operative complications, or overwhelming infection.

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 requirements,

Policy

Scenarios that may not qualify for critical care billing include:

- Patients in the post-operative period in the ICU without any additional ICU needs other than those related to post-operative issues (this is included in the global bill for surgical procedures)
- Patients who are admitted under palliative care, even if they are in the ICU
- Patients in the ICU who otherwise don't meet the criteria for critical care (e.g., the q1 hour eye drop patient)
- Critical care time of less than 30 minutes

Claims submitted with a diagnosis not supporting the definition of critical care may be denied for review.

Emergency Department

Critical care and emergency department services may both be reported on the same day when after completion of the emergency department service, the condition of the patient changes and critical care services are provided.

Based on the definition of critical illness (a requirement to submit critical care codes), critical care performed in the Emergency department where the patient is well enough to be discharged home on the same day, is unlikely to meet the definition of critical illness.

Elements of Critical Care

- Time = Total time spent evaluating, managing, and providing care to a critically ill patient must be documented and does not have to be continuous. Time includes direct patient care at bedside as well as time spent reviewing test results, discussing the case with consultants or family members, and documenting the patient's chart.
- Time spent in activities that occur outside of the unit or off the floor (Telephone calls whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the individual is not immediately available to the patient.
- Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care area (administrative meeting or telephone calls to discuss other patients. Time spent performing separately reportable procedures or services (intubation, CPR) should not be included in the time reported as critical care.

The following services are considered inclusive to the critical care codes when reported by the clinician:

- interpretation of cardiac output measurement,
- chest x-rays
- pulse oximetry
- blood gases

- collection and interpretation of physiologic data
- computer data such as ECGs
- gastric intubation
- vascular access
- ventilation management, including CPAP, CNP

When any of these services are reported in addition to critical care, payment for the services is included in the payment for critical care codes 99291 and 99292. Any services performed that are not listed should be reported separately.

Modifier FS for Split and Shared Visits

Modifier FS is correct for services provided as a split (shared) service between the physician and NPP in the same group. When time is used, as in critical care, the substantive portion means more than half of the total time.

Example: If the NPP first spent 10 minutes with the patient and the physician then spent another 30 minutes, their individual time spent would be summed to equal a total of 40 minutes. The physician would bill for this visit since they spent more than half of the total time (30 of 40 minutes in total).

Documentation in the medical record must identify the two individual practitioners who performed the split/shared visit. In addition, the individual who performed the substantive portion, and therefore bills the visit, must sign and date the medical record.

Time

CPT instructions and Medicare guidelines differ on time reporting for critical care. Blue KC will adhere to (time) reporting differences between CPT and Medicare.

CPT	Medicare
30-74 min 99291	30-103 min 99291
75-104 min 99291, 99292x1	104-133 min 99291, 99292x1
105-134 min 99291, 99292x2	134-163 min 99291, 99292x2
135-164 min 99291, 99292x3	164-193 min 99291, 99292x3

Coding

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)

References and Resources

American Medical Association https://www.ama-assn.org/topics/cpt-codes
AMA Exhibit 5, Example 2 – Distinguishing CPT and HCPCS Notes and Guidelines https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/ama-exhibit-5-2.pdf
CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 12: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104C12.pdf Critical care and another E/M service provided on the same date: section 30.6.12.H - Counting time and units: sections 30.6.12.E, F, https://www.cms.gov/files/document/r11288cp.pdf

Related Documents

Payment Policy POL-PP-236 CPT Evaluation and Management Guidelines

Payment Policy POL-PP-197 Emergency Care

Revision History

Version	Date	Summary of Revisions
001	9/1/2020	Initial version
002	9/1/2021	Annual Review, removed deleted codes 93561,93562, and 99090 from "services are considered part of critical care" deleted 1/1/2022
003	1/1/2023	Added AMA 2023 updates to time reporting and critical care billed with 99282-99285.
004	3/8/2023	Information was added on modifier FS
005	9/1/2023	Annual review, added to policy that claims submitted with a diagnosis not supporting critical care requirements may be denied
006	1/1/2024	Added new language defining substantive portion of a split/shared visit.
007	9/1/2024	Annual Review -Added additional information on the definition and documentation of critical care from the American College of Emergency Physicians. Changed wording from "not supporting critical care requirement may be denied" to "not supporting the definition of critical care may be denied for review'.
008	9/1/2025	Annual review- added examples of scenarios that would not qualify for critical care
009	10/1/2025	Links to references and resources were added
010	10/29/2025	Update, missing link added for Critical care and another E/M service provided on the same date: section 30.6.12.H - Counting time and units: sections 30.6.12.E, F, https://www.cms.gov/files/document/r11288cp.pdf