LifeWise
Health Plan of Washington

Payment Policy

cmi_171670

Title	**Critical Care in Emergency Department when Patient is Discharged to Home (Facility)**		
Number	**CP.PP.425.v1.1**		
Last Approval Date	04/07/25	**Original Effective Date**	10/30/24
Replaces			
Cross Reference			

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose/ Application	To define how the Plan recognizes Critical Care services submitted with an Emergency Department (ED) visit billed on an Outpatient facility claims (UB-04/CMS-1450 paper claim or 837I electronic claim form) when the patient is discharged to home during the same encounter.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Definitions	**Critical Care Services:** Services involving medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of 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.
Policy	Critical Care Services that are rendered during an Emergency Department (ED) encounter and which are billed on an Outpatient facility claim where the patient is discharged home on the same day or the day after the emergency room visit , are not considered reimbursable by the Plan. This applies to claims involving Current Procedural Terminology (CPT) codes 99291 and 99292 when billed in conjunction with the following criteria: • An Emergency Room visit, billed with Revenue Code series 045X, is present on the claim, • Discharge Status code 01 indicating the patient was discharged home; and • The admit and discharge dates are the same or the discharge date is one day beyond the admit date to indicate an encounter spanning midnight. Effective with claim dates of service on and after October 30, 2024, ED visits that meet the above-mentioned criteria are subject to denial as these services do **not** meet the requirements for critical care. Services provided to a non-critically ill or injured patient should be reported using another appropriate Evaluation and Management (E/M) procedure code.

Codes and Coding Guidelines	Claims must be billed according to CPT and The Centers for Medicare & Medicaid Services (CMS) guidelines for critical care. The procedure codes and discharge status codes addressed in this policy include the following: • **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.) • **Discharge status code 01: Discharge to home or self-care (Routine Discharge)** ○ **NOTE:** Includes discharge to home; home IV service from a Home IV provider; home on oxygen if DME only; any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs **NOTE:** + = Denotes an add-on code which must be billed with an appropriate primary procedure
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined at the Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	
Laws, Regulations & Standards	None
References and Resources	• CMS Publication 100-04-Claims Processing Manual, Chapter 12, Section 30.6.12-Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292 • American Medical Association's Current Procedural Terminology (AMA/CPT) codebook • American College of Emergency Physicians "Critical Care FAQs", https://www.acep.org/administration/reimbursement/reimbursement-faqs/critical-care-faq/ • Official UB-04 Data Specifications Manual, 2024 Edition, American Hospital Association

Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department
Annual Review Dates	04/07/25; 07/08/24

Version History	07/08/24	New payment policy created effective with claim dates of service on and after October 30, 2024.
	04/07/25	In the policy section: • Clarified the first paragraph content; • In the third paragraph, removed the "may be reviewed" statement, and • In the fourth paragraph, removed the example codes In the coding section: removed the other non-critical care example codes.