Critical Care Codes When Discharging Home Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Critical care codes (99291, 99292) are designated for services provided to critically ill patients in intensive care units and emergency departments. The AMA/CPT and CMS define critical illness or injury as a condition that acutely impairs one or more vital organ systems to such an extent that there is a high probability of imminent or life-threatening deterioration in the patient's condition.

Below, beginning on page 2, you will find a list of common examples published by the American College of Emergency Physicians.

Instances have been noted where critical care codes were submitted without justification based on the patient's condition, not being critical. Reasons for such submissions include providing services that can be used in critical care cases but on non-critically ill patients (such as parenteral medication administration), trauma team activation when no trauma arrives, and misinterpretation of disease severity.

Cases where critical care is administered to critically ill patients who are then discharged home may raise quality-of-care concerns, which can be reviewed upon appeal. A method to determine inappropriate submission of critical care codes is when these codes are submitted despite the patient being discharged to home. According to the definition of critical illness, it is improbable that a patient meeting these criteria would be well enough to avoid admission and be discharged home.

While it is possible for critically ill patients to opt not to be admitted and choose to die at home, these cases typically utilize a hospice discharge status code.

Discharge Status Codes to Home:

- **Discharge status code 01**: Discharge to Home or Self Care (Routine Discharge)
- **Discharge status code 50**: Discharged/Transferred to a Hospice Routine or Continuous Home Care - This code should be used if the patient went to his/her own home or an alternative setting considered as the patient's "home," such as a nursing facility, where they will receive in-home hospice services.

Coverage is subject to the specific terms of the member's benefit plan.

Critical illness or Injury: A condition that acutely impairs one or more vital organ systems with a high probability of imminent or life-threatening deterioration in the patient's condition.

- If an ED claim is submitted with a discharge status code of 01 and 99291 +/- 99292 are included on the claim, these codes would not be payable.

- If an ED claim is submitted with a discharge status code of 50 and 99291 +/- 99292 are included, these codes would be payable (subject to any applicable review process for verification).

CONDITIONS that frequently qualify for critical care billing	**INTERVENTIONS often associated with critical care billing**
Acute coronary syndrome with active chest pain	Arterial line placement
Acute hepatic failure	Burn care, major
Acute renal failure	Cardiopulmonary resuscitation
Acute respiratory failure	Chest tube insertion
Adrenal crisis	Cricothyrotomy
Aortic dissection	Defibrillation/ Cardioversion
Bleeding diatheses – aplastic anemia, DIC, hemophilia, ITP, leukemia, TTP	Delivery of baby
Burns threatening to life or limb	Emergent blood transfusions
Cardiac dysrhythmia requiring emergent treatment	Endotracheal intubation
Cardiac tamponade	Hemorrhage control, major
Coma (most etiologies, except simple hypoglycemic)	Intravenous pacemaker insertion
Diabetic ketoacidosis or non-kenotic hyperosmolar syndrome	Invasive rewarming
Drug overdose	Non-invasive positive pressure ventilation (i.e., BiPAP or CPAP)
Ectopic pregnancy with hemorrhage	Pericardiocentesis
Embolus of fat or amniotic fluid	Therapeutic hypothermia
Envenomation	Trauma care requiring multiple surgical interventions or consultants
Gastrointestinal bleeding	Ventilator management
Head injury with loss of consciousness	Parenteral medications necessitating continuous monitoring, such as: • ACLS medications administered during cardiac arrest • Insulin infusions • Medications for heart rate/rhythm control • Naloxone infusions • Vasoactive medications

CONDITIONS that frequently qualify for critical care billing	INTERVENTIONS often associated with critical care billing
Hyperkalemia	
Hyper- or hypothermia	
Hypertensive emergency	
Ischemia of limb, bowel, or retina	
Lactic acidosis	
Multiple trauma	
Paralysis (new onset)	
Perforated abdominal viscous	
Pulmonary embolism	
Ruptured aneurysm	
Shock, all etiologies (septic, cardiogenic, spinal, hypovolemic, anaphylactic)	
Stroke, hemorrhagic (all etiologies) or ischemia	
Status epilepticus	
Tension pneumothorax	
Thyroid storm	

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Procedure Codes (CPT & HCPCS)

Code	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)

Supplemental Information

Definitions

Term	Definition
CMS	Center for Medicare and Medicaid Services

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Initial Creation	8/19/2022	New Policy
Revised Date	8/16/2023	Updated links and added code descriptions
Revised Date	12/12/2024	Updated Template and Links
Revised Date	8/1/2025	Updated Template

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
CMS	100-04 Chapter 12 Transmittal 2997 30.6.12 A & B
CPT®/AMA	CPT Professional Edition Pg 31

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*