Payment Policy: Critical Care in Emergency Department when Patient is Discharged to Home

Reference Number: SC.CC.PP.502
Product Types: Medicare
Effective Date: 08/01/2025
Last Review Date:

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Critical care codes (99291, 99292) represent, as defined by defined by AMA/CPT and CMS, services provided to 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.

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 patients who are then discharged to home may raise quality of care concerns. 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 unlikely that a patient meeting these criteria would be well enough to avoid admission and be discharged to home. Critically ill patients that opt not to be admitted and choose to die at home, typically utilize a hospice discharge status code.

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.

Application
This applies to claims involving Current Procedural Terminology (CPT) codes 99291 and 99292 when billed in conjunction with the following criteria:

- An ED 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.

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

Appeals/Reconsiderations
To ensure proper reimbursement when billing high intensity E&M codes, providers must show documentation that supports medical necessity. The provider may submit an appeal/reconsideration request according to provider manual guidelines. All pertinent medical records for the date of service and procedures billed should be submitted. Medical records should not be submitted on first-time claims, as first-time claim review consists only of a review of the information documented on the claim and in the member/provider history. Medical records should only be submitted if the provider receives a denial and wishes to request a reconsideration or appeal.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2016 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Code	Descriptor
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)

ICD-10 Codes	Descriptor
NA	NA

Definitions

Evaluation and Management (E&M)
Physician-patient encounters that are translated into five-digit CPT codes for billing purposes. Different E&M codes exist for different patient encounters such as office visits, hospital visits, home visits and etc. Each patient encounter has different levels of care. For example, Initial Hospital Care has three levels of care for this encounter (99221, 99222 and 99223).

Additional Information
https://oig.hhs.gov/oei/reports/oei-04-10-00181.pdf

Related Documents or Resources

Policy Number	Policy
CC.PP.021	Clean Claims

References

1. *Current Procedural Terminology (CPT)®*
2. *Centers for Medicare and Medicaid Services Medicare Claims Processing Manual; Section 30.6.12 A*
3. *Centers for Medicare and Medicaid Services Medicare Claims Processing Manual; Section 30.6.12 B*

Revision History	
08/01/2025	Initial Policy Draft Created

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.