Reimbursement Policy

Critical Care Services

REIMBURSEMENT POLICY NUMBER: 25

Effective Date: 1/1/2026

Last Review Date: 12/2025

Next Annual Review: 5/2026

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☒ Professional Claims

☐ DMEPOS Suppliers

☐ All health care services billed on CMS 1500 forms

☒ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☐ Facilities

☐ All health care services billed on UB04 forms (CMS 1450)

Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

Plan Product:

☒ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

☐ DRG

☐ Modified DRG

☐ Percentage of billed charges/per diem

POLICY STATEMENT

I. Providence Health Plan reimburses for critical care services when they are billed in accordance with CPT® guidelines and CMS policies. Critical care services must involve the direct delivery of medical care for a critically ill or injured patient, where there is a high probability of imminent or life-threatening deterioration.

II. Providence Health Plan will consider critical care services for **reimbursement** when **all** of the following elements of critical care are met:

A. Requires direct patient/provider involvement
B. Includes highly complex decision making.
C. Generally, these services require the interpretation of many physiologic parameters and applications of advanced technology available for use during the care of the patient.
D. Time based using the total time spent performing direct patient care and performing documentation.

III. Review is not based on medical necessity but on the CPT definition based on the criterion below:

A. **Clinical Condition Criterion**: There is a high probability of sudden, clinically significant or threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently.
B. **Treatment Criterion Critical:** care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.

IV. CPT provides the following examples where critical care may be warranted:

A. Central nervous system failure
B. Circulatory system failure and shock
C. Renal, hepatic, metabolic, and/or respiratory failure

Note: immaturity alone is not indicative of the need to initiate critical care services.

V. Care provided to patients residing in a critical care unit but not fitting the criteria for critical care is reported using the appropriate Evaluation and Management procedure code.

VI. Time:

A. The total time spent must be documented and can include direct patient care at bedside, time spent reviewing test results, discussing the case with consultants or family members and completing documentation.
B. Time spent outside of the patient's unit or floor, including telephone calls, caregiver discussions, or time spent in actions that do not directly contribute to the patient's care rendered in the critical unit are not reported as critical care.
C. 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.
D. If services provided equal less than 30 minutes, than the appropriate Evaluation and Management code should be reported.
E. Critical care may be provided if the patient's condition continues to warrant the level of care to meet criteria. Also, critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of attention described above.

VII. The following services are considered inclusive and included in the payment of critical care codes when reported by the provider:

A. Blood gases
B. Chest films (71045-71046)
C. Measurement cardiac output (93598)
D. Other computer stored information
E. Pulse oximetry (94760-94762)
F. Gastric intubation (43752-43753)
G. Transcutaneous pacing, temporary (92953)
H. Venous access, arterial puncture (36000, 36410, 36415, 36591, 36600)
I. Ventilation assistance and management, includes CPAP, CNP (94002-94004, 94660)

VIII. 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.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to provide an effective and accurate review, the following documentation **must** be provided. If any of these items are not submitted, the review may be delayed and any decision outcome could be affected. Critical care is a time-based service. Practitioners must document:

1. Services performed.
2. Total time.
3. The distinct role each specialty furnishing critical care played in the patient care and conditions.
4. For split/shared critical care visits:
    a. The practitioners involved.
    b. Relative time spent by each.
    c. Shared/overlapping time (which can only be counted once).
    d. Services performed.
    e. Time spent in the performance of other services reported separately to show this time was not counted towards the critical care visit.

DEFINITIONS

Critical Illness: Illness or injury that acutely impairs one or more vital organ system(s), such that there is a high probability of imminent or life-threatening deterioration in the patient's condition.[1]

Critical Care Service: delivery of medical care for a critically ill/injured patient. It involves high complexity decision making to assess, manipulate, and support vital organ system failure and prevent further life-threatening deterioration.[1]

Table 1: CPT Codes Addressed in this Policy

CPT Codes	
99291-99292	Critical care services for patients age six years or older
99475-99476	Inpatient critical care services provided to child age 2 through 5 years old
99471-99472	Inpatient critical care services provided to infants age 29 days through 24 months old
99468-99469	Inpatient critical care services provided to neonates age 28 days or younger

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 7/1/2025, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses inpatient hospital readmissions:

- Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292): Definition. Medicare Claims Processing Manual (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.1.
- Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care). Medicare Claims Processing Manual (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.4.
- Critical Care by a Single Physician or NPP. Medicare Claims Processing Manual (Pub. 1004). Chapter 12 – Physician Practitioner Billing, § 30.6.12.2.
- Critical Care Visits Furnished Concurrently by Different Specialties. Medicare Claims Processing Manual (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.3.

- Critical Care, Medical Record Documentation. Medicare Claims Processing Manual (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.8.
- Split (or Shared) Critical Care Visits. Medicare Claims Processing Manual (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.5.

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding inpatient hospital readmissions.

CROSS REFERENCES

None

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. American Medical Association – Current Procedural Terminology (CPT). Critical Care Services. 2025, Professional Edition.
2. Centers for Medicare & Medicaid (CMS). Medicare Claims Processing Manual (Pub. 100-4). Chapter 12 – Physician Practitioner Billing. Last Accessed 6/29/2025. LINK.

POLICY REVISION HISTORY

Date	Revision Summary
8/4/2025	New policy
1/2026	Q1 2026 code updates