Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-034		
Subject:	Prolonged Detention or Critical Care		
Effective Date:	May 7, 2018	**End Date:**	
Issue Date:	April 1, 2024	**Revised Date:**	April 2024
Date Reviewed:	February 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy provides direction on the Plan's reimbursement of prolonged detention, critical care and ventilator management services. Prolonged detention or critical care is a specific service which requires the continuous presence of the doctor in the immediate vicinity of the patient while providing a service which only he or she can provide. Ventilator management is a form of critical care not to be distinguished from other forms of prolonged detention or critical care for other conditions.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Note: Commercial reimbursement guidelines are only applicable to professional (1500) claims.

Prolonged Detention or Critical Care

The terminology for critical care codes 99291 and 99292 specifies the codes and number of services billed for these services rendered by a physician must be reported using the actual amount of time spent with the patient. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate evaluation and management (E&M) code.

Code 99291 is used to report the first 30-74 minutes of critical care on any given date. It should be used only once per date, even if the time spent by the physician is not continuous on that date. Reimbursement may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty.

Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date. Critical care services of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes are not separately reported.

The service codes listed below are considered part of critical care services (codes 99291 and 99292) when performed on the same day, by the same critical care physician. When any of the services below are reported in addition to critical care, reimbursement for the service(s) is included in the reimbursement for the critical care codes 99291 and 99292.

Applicable Codes:

36000	36591	43752	71045	71047	92953	94002	94004	94662	94761
36410	36600	43753	71046	71048	93598	94003	94660	94760	94762
36415									

Note: Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if the practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care, the visit was medically necessary, and the services are separate and distinct, with no duplicative elements from the critical care service provided later in the day. Modifier 25 must be reported on the claim line when reporting these critical care services and the patient's records must clearly document a separately identifiable medical care service was rendered.

Critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma, burn cases). **Modifier FT** must be reported on the claim line to identify that the critical care is unrelated to the procedure. If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), the appropriate modifiers must also be reported to indicate the transfer of care and the patient's records must clearly document and support the separate billing of services.

Critical care visits can be furnished as split or shared visits and should be reported with **Modifier FS** appended to the claim line(s). Split or shared visits can be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged visits. Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record. The substantive portion of critical care can only be more than half the total time spent. The visit is billed by only the physician or practitioner who provides the substantive portion of the visit.

Transportation of Critically Ill Patients

In cases involving either maternal or neonatal retrieval, the physician's attendance, while he or she personally renders care to the patient, should be reimbursed as prolonged detention or critical care.

Additionally, when it is medically necessary to transport a critically ill patient (inpatient or OP emergent) from one hospital to another more specialized hospital, the physician's attendance while he personally renders care to the patient will be reimbursed as prolonged detention or critical care.

Applicable Codes: 99291 99292 99466 99467 94760 94761 94762

Note: Payment may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty. When modifier 25 is reported, the patient's records must clearly document that a separately identifiable medical care service was rendered.

Ventilator Management

Ventilator Management is applicable to patients of all ages, as well as neonates who are on respirators. Claims reporting only ventilator management will be reimbursed for those codes.

Applicable Codes: 94002 94003 94004 94660 94662

However, when critical care, pediatric critical care, pediatric critical care transport, neonatal critical care, or subsequent intensive care and ventilator management are reported on the same day by the same provider, the ventilator management service is included in the payment for the critical care and neonatal intensive care, with reimbursement being made for the critical care or neonatal intensive care, only.

Note: Modifiers 59, XE, XP, XS and XU may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifiers 59, XE, XP, XS and XU are reported, the patient's records must support its use in accordance with CPT guidelines.

Applicable Codes:

99291	99466	99468	99471	99475	99477	99479
99292	99467	99469	99472	99476	99478	99480

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Note: Medicare Advantage reimbursement guidelines are applicable to facility (UB) and professional (1500) claims.

Requirements for Physician Presence:

- Physicians may only count the duration of direct face to face contact between the physician and the member (whether the service was continuous or not) beyond the typical/average time of the E/M visit code billed. Reference E&M times should be used as the basis for determining whether prolonged services are appropriate to bill and determine the prolonged services codes allowable under this policy.
- Office Place of Service: In case of prolonged office services, time spent by office staff with the member, or time the member remains unaccompanied in the office cannot be billed.

- Facility Place of Service: All of the following situations are examples which fail to qualify for billing Prolonged Services:

    - Time spent reviewing charts
    - Discussion of a member's case with the house medical staff without direct member contact.
    - Waiting for test results
    - Waiting for changes in the member's condition
    - Waiting for end of therapy
    - Waiting for the use of facilities

Prolonged Service codes can be billed only if the total duration of the physician or other qualified Non-Physician Practitioner (NPP) direct face to face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes).

If the total duration of direct face to face time does not equal the services provided by the physician or qualified NPP, the physician or qualified NPP may not bill for prolonged service.

Reporting Prolonged Services

Practitioners will select the appropriate procedure code for Office/Outpatient Evaluation and Management that includes a medically appropriate history and exam, when performed. Practitioners should perform history and exam to the extent clinically appropriate, reasonable and necessary.

When the practitioner selects a visit level using time spent, the practitioner may report prolonged office/ outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office and outpatient E/M services). Practitioners should not report prolonged office outpatient E/M visit time using CPT codes 99358 and 99359 (Prolonged service without direct patient contact). The following table provides reporting examples.

- Prolonged Office/Outpatient E/M Visit Reporting – New Patient

HCPCS Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes

- Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

HCPCS Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

List add-on code G2211 separately in addition to office/outpatient evaluation and management visit, new or established.

Note: Do not report G2212 on the same date of service as 99358, 99359, 99415, 99416. Do not report G2212 for any time unit less than 15 minutes.

Reporting Visit Complexity

HCPCS add on code G2211 describing visit complexity inherent to office/outpatient E/M visits associated with medical services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of an ongoing care related to a patient's single, serious or complex condition and may be reported with any visit level.

This code reflects the time, intensity, and practice expense when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing patients' ongoing services that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

List add-on code G2211 separately in addition to office/outpatient evaluation and management visit, new or established.

Reporting Services for an Inpatient Setting

Use hospital care codes 99221-99223, 99231-99232, nursing facility service codes 99304-99310, 99315, 99316 and 99318.

Reporting Prolonged Services without direct face-to-face patient contact service

Prolonged E/M services before and after direct member care, which do not require any direct member face-to-face contact are considered separately payable under the physician fee schedule.

Procedure codes 99358 and 99359 cannot be reported during the same service period as complex chronic care management (CCM) services or transitional care management services. 99358 and 99359 can only be used to report extended qualifying time of the billing physician or other practitioner (not including clinical staff). Prolonged services cannot be reported with a companion E/M code which also qualifies as the initiating visit for chronic care management (CCM) services if applicable providers should report the add- on code for CCM initiation.

Prolonged Services Associated with Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be "rounded" to the next higher level.

In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

DEFINITIONS:

Modifier	Definition
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day.
59	Distinct procedural service.
FT	Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit. (Report when an E/M visit is furnished within the global period but is unrelated, or when one more additional E/M visits furnished on the same day are unrelated.
FS	Split (or shared) evaluation and management visit.
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter.
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner.
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure.
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-010: Incident-To Billing
- RP-035: Correct Coding Guidelines
- RP-037: Emergency Evaluation and Management Coding Guidelines
- RP-041: Services Not Separately Reimbursed
- RP-057: Evaluation and Management Services
- RP-065: Modifier Reduction Glossary

MEDICARE ADVANTAGE REFERENCES:

- MLN Matters MM12071, Transmittal R10505CP, CR 12071. Effective January 1, 2021.
- CMS Internet Only Manual (IOM), Medicare Claims Processing Manual, Pub. 100-04, Transmittal 1875, CR 6740. Effective January 1, 2010.

POLICY UPDATE HISTORY INFORMATION:

5 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy

1 / 2022	Removed 93561 and 93562. Added direction for modifier FT and FS.
6 / 2022	Removed Medical Policy Z-34
8 / 2023	Administrative policy review with no changes in policy direction
2 / 2024	Added Medicare Advantage direction merged from MRP-004
4 / 2024	Added code 93598

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-034		
Subject:	Prolonged Detention or Critical Care		
Effective Date:	May 7, 2018	**End Date:**	
Issue Date:	February 19, 2024	**Revised Date:**	February 2024
Date Reviewed:	January 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
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COMMERCIAL REIMBURSEMENT GUIDELINES:

Note: Commercial reimbursement guidelines are only applicable to professional (1500) claims.

Prolonged Detention or Critical Care

The terminology for critical care codes 99291 and 99292 specifies the codes and number of services billed for these services rendered by a physician must be reported using the actual amount of time spent with the patient. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate evaluation and management (E&M) code.

Code 99291 is used to report the first 30-74 minutes of critical care on any given date. It should be used only once per date, even if the time spent by the physician is not continuous on that date. Reimbursement may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty.

Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date. Critical care services of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes are not separately reported.

The service codes listed below are considered part of critical care services (codes 99291 and 99292) when performed on the same day, by the same critical care physician. When any of the services below are reported in addition to critical care, reimbursement for the service(s) is included in the reimbursement for the critical care codes 99291 and 99292.

Applicable Codes:

36000	36591	43752	71045	71047	92953	94002	94004	94662	94761
36410	36600	43753	71046	71048	94003	94660	94760	94762	36415

Note: Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if the practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care, the visit was medically necessary, and the services are separate and distinct, with no duplicative elements from the critical care service provided later in the day. Modifier 25 must be reported on the claim line when reporting these critical care services and the patient's records must clearly document a separately identifiable medical care service was rendered.

Critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma, burn cases). **Modifier FT** must be reported on the claim line to identify that the critical care is unrelated to the procedure. If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), the appropriate modifiers must also be reported to indicate the transfer of care and the patient's records must clearly document and support the separate billing of services.

Critical care visits can be furnished as split or shared visits and should be reported with **Modifier FS** appended to the claim line(s). Split or shared visits can be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged visits. Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record. The substantive portion of critical care can only be more than half the total time spent. The visit is billed by only the physician or practitioner who provides the substantive portion of the visit.

Transportation of Critically Ill Patients

In cases involving either maternal or neonatal retrieval, the physician's attendance, while he or she personally renders care to the patient, should be reimbursed as prolonged detention or critical care.

Additionally, when it is medically necessary to transport a critically ill patient (inpatient or OP emergent) from one hospital to another more specialized hospital, the physician's attendance while he personally renders care to the patient will be reimbursed as prolonged detention or critical care.

Applicable Codes: 99291 99292 99466 99467 94760 94761 94762

Note: Payment may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty. When modifier 25 is reported, the patient's records must clearly document that a separately identifiable medical care service was rendered.

Ventilator Management

Ventilator Management is applicable to patients of all ages, as well as neonates who are on respirators. Claims reporting only ventilator management will be reimbursed for those codes.

Applicable Codes: 94002 94003 94004 94660 94662

However, when critical care, pediatric critical care, pediatric critical care transport, neonatal critical care, or subsequent intensive care and ventilator management are reported on the same day by the same provider, the ventilator management service is included in the payment for the critical care and neonatal intensive care, with reimbursement being made for the critical care or neonatal intensive care, only.

Note: Modifiers 59, XE, XP, XS and XU may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifiers 59, XE, XP, XS and XU are reported, the patient's records must support its use in accordance with CPT guidelines.

Applicable Codes: 99291 99466 99468 99471 99475 99477 99479
99292 99467 99469 99472 99476 99478 99480

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Note: Medicare Advantage reimbursement guidelines are applicable to facility (UB) and professional (1500) claims.

Requirements for Physician Presence:

- Physicians may only count the duration of direct face to face contact between the physician and the member (whether the service was continuous or not) beyond the typical/average time of the E/M visit code billed. Reference E&M times should be used as the basis for determining whether prolonged services are appropriate to bill and determine the prolonged services codes allowable under this policy.

- Office Place of Service: In case of prolonged office services, time spent by office staff with the member, or time the member remains unaccompanied in the office cannot be billed.

- Facility Place of Service: All of the following situations are examples which fail to qualify for billing Prolonged Services:

    - Time spent reviewing charts
    - Discussion of a member's case with the house medical staff without direct member contact.
    - Waiting for test results
    - Waiting for changes in the member's condition
    - Waiting for end of therapy
    - Waiting for the use of facilities

Prolonged Service codes can be billed only if the total duration of the physician or other qualified Non-Physician Practitioner (NPP) direct face to face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes).

If the total duration of direct face to face time does not equal the services provided by the physician or qualified NPP, the physician or qualified NPP may not bill for prolonged service.

Reporting Prolonged Services

Practitioners will select the appropriate procedure code for Office/Outpatient Evaluation and Management that includes a medically appropriate history and exam, when performed. Practitioners should perform history and exam to the extent clinically appropriate, reasonable and necessary.

When the practitioner selects a visit level using time spent, the practitioner may report prolonged office/ outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office and outpatient E/M services). Practitioners should not report prolonged office outpatient E/M visit time using CPT codes 99358 and 99359 (Prolonged service without direct patient contact). The following table provides reporting examples.

- Prolonged Office/Outpatient E/M Visit Reporting – New Patient

HCPCS Code(s)	Total Time Required for Reporting*
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99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes

- Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

HCPCS Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

List add-on code G2211 separately in addition to office/outpatient evaluation and management visit, new or established.

Note: Do not report G2212 on the same date of service as 99358, 99359, 99415, 99416. Do not report G2212 for any time unit less than 15 minutes.

Reporting Visit Complexity

HCPCS add on code G2211 describing visit complexity inherent to office/outpatient E/M visits associated with medical services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of an ongoing care related to a patient's single, serious or complex condition and may be reported with any visit level.

This code reflects the time, intensity, and practice expense when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing patients' ongoing services that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

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Prolonged Services Associated with Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be "rounded" to the next higher level.

In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

DEFINITIONS:

Modifier	Definition
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day.
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RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

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MEDICARE ADVANTAGE REFERENCES:

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POLICY UPDATE HISTORY INFORMATION:

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2 / 2024	Added Medicare Advantage direction merged from MRP-004

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Issue Date:	August 7, 2023	**Revised Date:**	August 2023
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Prolonged Detention or Critical Care

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Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date. Critical care services of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes are not separately reported.

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36000	36415	36600	43753	71046	71048	94002	94004	94662	94761
36410	36591	43752	71045	71047	92953	94003	94660	94760	94762

Note: Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if the practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care, the visit was medically necessary, and the services are separate and distinct, with no duplicative elements from the critical care service provided later in the day. **Modifier 25** must be reported on the claim line when reporting these critical care services and the patient's records must clearly document a separately identifiable medical care service was rendered.

Critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma, burn cases). **Modifier FT** must be reported on the claim line to identify that the critical care is unrelated to the procedure. If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), the appropriate modifiers must also be reported to indicate the transfer of care and the patient's records must clearly document and support the separate billing of services.

Critical care visits can be furnished as split or shared visits and should be reported with **Modifier FS** appended to the claim line(s). Split or shared visits can be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged visits. Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record. The substantive portion of critical care can only be more than half the total time spent. The visit is billed by only the physician or practitioner who provides the substantive portion of the visit.

Transportation of Critically Ill Patients

In cases involving either maternal or neonatal retrieval, the physician's attendance, while he or she personally renders care to the patient, should be reimbursed as prolonged detention or critical care.

Additionally, when it is medically necessary to transport a critically ill patient (inpatient or OP emergent) from one hospital to another more specialized hospital, the physician's attendance while he personally renders care to the patient will be reimbursed as prolonged detention or critical care.

Applicable Codes: 99291 99292 99466 99467 94760 94761 94762

Note: Payment may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty. When modifier 25 is reported, the patient's records must clearly document that a separately identifiable medical care service was rendered.

Ventilator Management

Ventilator Management is applicable to patients of all ages, as well as neonates who are on respirators. Claims reporting only ventilator management will be reimbursed for those codes.

Applicable Codes: 94002 94003 94004 94660 94662

However, when critical care, pediatric critical care, pediatric critical care transport, neonatal critical care, or subsequent intensive care and ventilator management are reported on the same day by the same provider, the ventilator management service is included in the payment for the critical care and neonatal intensive care, with reimbursement being made for the critical care or neonatal intensive care, only.

Note: Modifiers 59, XE, XP, XS and XU may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifiers 59, XE, XP, XS and XU are reported, the patient's records must support its use in accordance with CPT guidelines.

Applicable Codes: 99291 99466 99468 99471 99475 99477 99479
99292 99467 99469 99472 99476 99478 99480

DEFINITIONS:

Modifier	Definition
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day.
59	Distinct procedural service.
FT	Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit. (Report when an E/M visit is furnished within the global period but is unrelated, or when one more additional E/M visits furnished on the same day are unrelated.
FS	Split (or shared) evaluation and management visit.
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter.
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner.
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure.
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-010: Incident-To Billing
- RP-035: Correct Coding Guidelines
- RP-037: Emergency Evaluation and Management Coding Guidelines
- RP-057: Evaluation and Management Services
- RP-065: Modifier Reduction Glossary

POLICY UPDATE HISTORY INFORMATION:

5 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Removed 93561 and 93562. Added direction for modifier FT and FS.
6 / 2022	Removed Medical Policy Z-34
8 / 2023	Administrative policy review with no changes in policy direction

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

HIGHMARK.

Bulletin Number:	RP-034		
Subject:	Prolonged Detention or Critical Care		
Effective Date:	May 7, 2018	**End Date:**	
Issue Date:	July 18, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy provides direction on the Plan's reimbursement of prolonged detention, critical care and ventilator management services. Prolonged detention or critical care is a specific service which requires the continuous presence of the doctor in the immediate vicinity of the patient while providing a service which only he or she can provide. Ventilator management is a form of critical care not to be distinguished from other forms of prolonged detention or critical care for other conditions.

REIMBURSEMENT GUIDELINES:

Prolonged Detention or Critical Care

The terminology for critical care codes 99291 and 99292 specifies the codes and number of services billed for these services rendered by a physician must be reported using the actual amount of time spent with the patient. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate evaluation and management (E&M) code.

Code 99291 is used to report the first 30-74 minutes of critical care on any given date. It should be used only once per date, even if the time spent by the physician is not continuous on that date. Reimbursement may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty.

Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date. Critical care services of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes are not separately reported.

The service codes listed below are considered part of critical care services (codes 99291 and 99292) when performed on the same day, by the same critical care physician. When any of the services below are reported in addition to critical care, reimbursement for the service(s) is included in the reimbursement for the critical care codes 99291 and 99292.

Applicable Codes:

36000	36415	36600	43753	71046	71048	94002	94004	94662	94761
36410	36591	43752	71045	71047	92953	94003	94660	94760	94762

Note: Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if the practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care, the visit was medically necessary, and the services are separate and distinct, with no duplicative elements from the critical care service provided later in the day. **Modifier 25** must be reported on the claim line when reporting these critical care services and the patient's records must clearly document a separately identifiable medical care service was rendered.

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Critical care visits can be furnished as split or shared visits and should be reported with **Modifier FS** appended to the claim line(s). Split or shared visits can be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged visits. Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record. The substantive portion of critical care can only be more than half the total time spent. The visit is billed by only the physician or practitioner who provides the substantive portion of the visit.

Transportation of Critically Ill Patients

In cases involving either maternal or neonatal retrieval, the physician's attendance, while he or she personally renders care to the patient, should be reimbursed as prolonged detention or critical care.

Additionally, when it is medically necessary to transport a critically ill patient (inpatient or OP emergent) from one hospital to another more specialized hospital, the physician's attendance while he personally renders care to the patient will be reimbursed as prolonged detention or critical care.

Applicable Codes: 99291 99292 99466 99467 94760 94761 94762

Note: Payment may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty. When modifier 25 is reported, the patient's records must clearly document that a separately identifiable medical care service was rendered.

Ventilator Management

Ventilator Management is applicable to patients of all ages, as well as neonates who are on respirators. Claims reporting only ventilator management will be reimbursed for those codes.

Applicable Codes: 94002 94003 94004 94660 94662

However, when critical care, pediatric critical care, pediatric critical care transport, neonatal critical care, or subsequent intensive care and ventilator management are reported on the same day by the same provider, the ventilator management service is included in the payment for the critical care and neonatal intensive care, with reimbursement being made for the critical care or neonatal intensive care, only.

Note: Modifiers 59, XE, XP, XS and XU may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifiers 59, XE, XP, XS and XU are reported, the patient's records must support its use in accordance with CPT guidelines.

Applicable Codes:

99291	99466	99468	99471	99475	99477	99479
99292	99467	99469	99472	99476	99478	99480

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-010: Incident-To Billing
- RP-037: Emergency Evaluation and Management Coding Guidelines
- RP-057: Evaluation and Management Services
- RP-065: Modifier Reduction Glossary

POLICY UPDATE HISTORY INFORMATION:

5 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy

1 / 2022	Removed 93561 and 93562. Added direction for modifier FT and FS.
6 / 2022	Removed Medical Policy Z-34

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-034		
Subject:	Prolonged Detention or Critical Care		
Effective Date:	May 7, 2018	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	December 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy provides direction on the Plan's reimbursement of prolonged detention, critical care and ventilator management services. Prolonged detention or critical care is a specific service which requires the continuous presence of the doctor in the immediate vicinity of the patient while providing a service which only he or she can provide. Ventilator management is a form of critical care not to be distinguished from other forms of prolonged detention or critical care for other conditions.

REIMBURSEMENT GUIDELINES:

Prolonged Detention or Critical Care

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Code 99291 is used to report the first 30-74 minutes of critical care on any given date. It should be used only once per date, even if the time spent by the physician is not continuous on that date. Reimbursement may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty.

Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date. Critical care services of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes are not separately reported.

The service codes listed below are considered part of critical care services (codes 99291 and 99292) when performed on the same day, by the same critical care physician. When any of the services below are reported in addition to critical care, reimbursement for the service(s) is included in the reimbursement for the critical care codes 99291 and 99292.

Applicable Codes:

36000	36415	36600	43753	71046	71048	94002	94004	94662	94761
36410	36591	43752	71045	71047	92953	94003	94660	94760	94762

Note: Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if the practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care, the visit was medically necessary, and the services are separate and distinct, with no duplicative elements from the critical care service provided later in the day. **Modifier 25** must be reported on the claim line when reporting these critical care services and the patient's records must clearly document a separately identifiable medical care service was rendered.

Critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma, burn cases). **Modifier FT** must be reported on the claim line to identify that the critical care is unrelated to the procedure. If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), the appropriate modifiers must also be reported to indicate the transfer of care and the patient's records must clearly document and support the separate billing of services.

Critical care visits can be furnished as split or shared visits and should be reported with **Modifier FS** appended to the claim line(s). Split or shared visits can be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged visits. Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record. The substantive portion of critical care can only be more than half the total time spent. The visit is billed by only the physician or practitioner who provides the substantive portion of the visit.

Transportation of Critically Ill Patients

In cases involving either maternal or neonatal retrieval, the physician's attendance, while he or she personally renders care to the patient, should be reimbursed as prolonged detention or critical care.

Additionally, when it is medically necessary to transport a critically ill patient (inpatient or OP emergent) from one hospital to another more specialized hospital, the physician's attendance while he personally renders care to the patient will be reimbursed as prolonged detention or critical care.

Applicable Codes: 99291 99292 99466 99467 94760 94761 94762

Note: Payment may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty. When modifier 25 is reported, the patient's records must clearly document that a separately identifiable medical care service was rendered.

Ventilator Management

Ventilator Management is applicable to patients of all ages, as well as neonates who are on respirators. Claims reporting only ventilator management will be reimbursed for those codes.

Applicable Codes: 94002 94003 94004 94660 94662

However, when critical care, pediatric critical care, pediatric critical care transport, neonatal critical care, or subsequent intensive care and ventilator management are reported on the same day by the same provider, the ventilator management service is included in the payment for the critical care and neonatal intensive care, with reimbursement being made for the critical care or neonatal intensive care, only.

Note: Modifiers 59, XE, XP, XS and XU may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifiers 59, XE, XP, XS and XU are reported, the patient's records must support its use in accordance with CPT guidelines.

Applicable Codes: 99291 99466 99468 99471 99475 99477 99479
99292 99467 99469 99472 99476 99478 99480

RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-34: Status of Patient vs. Place of Service

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-010: Incident-To Billing
- RP-037: Emergency Evaluation and Management Coding Guidelines
- RP-057: Evaluation and Management Services
- RP-065: Modifier Reduction Glossary

POLICY UPDATE HISTORY INFORMATION:

5 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Removed 93561 and 93562. Added direction for modifier FT and FS.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-034		
Subject:	Prolonged Detention or Critical Care		
Effective Date:	May 7, 2018	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy provides direction on the Plan's reimbursement of prolonged detention, critical care and ventilator management services. Prolonged detention or critical care is a specific service which requires the continuous presence of the doctor in the immediate vicinity of the patient while providing a service which only he or she can provide. Ventilator management is a form of critical care not to be distinguished from other forms of prolonged detention or critical care for other conditions.

REIMBURSEMENT GUIDELINES:

Prolonged Detention or Critical Care

The terminology for critical care codes 99291 and 99292 specifies the codes and number of services billed for these services rendered by a physician must be reported using the actual amount of time spent with the patient.

Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E&M code.

Code 99291 is used to report the first 30-74 minutes of critical care on any given date. It should be used only once per date, even if the time spent by the physician is not continuous on that date. Reimbursement may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty.

Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date.

Critical care services of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes are not separately reported.

The service codes listed below are considered part of critical care services (codes 99291 and 99292) when performed on the same day, by the same critical care physician. When any of the services below are reported in addition to critical care, reimbursement for the service(s) is included in the reimbursement for the critical care codes 99291 and 99292.

Applicable Codes:

36000	36410	36415	36591	36600	43752	43753	71045	71046
71047	71048	92953	93561	93562	94002	94003	94004	94660
94662	94760	94761	94762					

Note: Modifier 25 may be reported with medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 is reported, the patient's records must clearly document a separately identifiable medical care service was rendered.

Transportation of Critically Ill Patients

In cases involving either maternal or neonatal retrieval, the physician's attendance, while he or she personally renders care to the patient, should be reimbursed as prolonged detention or critical care.

Additionally, when it is medically necessary to transport a critically ill patient (inpatient or OP emergent) from one hospital to another more specialized hospital, the physician's attendance while he personally renders care to the patient will be reimbursed as prolonged detention or critical care.

Applicable Codes:

99291	99292	99466	99467	94760	94761	94762

Note: Payment may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty. When modifier 25 is reported, the patient's records must clearly document that a separately identifiable medical care service was rendered.

Ventilator Management

Ventilator Management is applicable to patients of all ages, as well as neonates who are on respirators. Claims reporting only ventilator management will be reimbursed for those codes.

Applicable Codes:

94002	94003	94004	94660	94662

However, when critical care, pediatric critical care, pediatric critical care transport, neonatal critical care, or subsequent intensive care and ventilator management are reported on the same day by the same provider, the ventilator management service is included in the payment for the critical care and neonatal intensive care, with reimbursement being made for the critical care or neonatal intensive care, only.

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Applicable Codes:

99291	99292	99466	99467	99468	99469	99471	99472	99475
99476	99466	99477	99478	99479	99480			

RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-34: Status of Patient vs. Place of Service

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS and XU

POLICY UPDATE HISTORY INFORMATION:

5 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

HIGHMARK.

CLICK HERE FOR HISTORY VERSIONS

Bulletin Number:	RP-034		
Subject:	Prolonged Detention or Critical Care		
Effective Date:	May 7, 2018	**End Date:**	
Issue Date:	December 27, 2018	**Revised Date:**	December 13, 2018
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

PURPOSE:

This policy provides direction on The Plan's reimbursement of prolonged detention, critical care and ventilator management services. Prolonged detention or critical care is a specific service which requires the continuous presence of the doctor in the immediate vicinity of the patient while providing a service which only he or she can provide. Ventilator management is a form of critical care not to be distinguished from other forms of prolonged detention or critical care for other conditions.

REIMBURSEMENT GUIDELINES:

Prolonged Detention or Critical Care

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Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E&M code.

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may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty.

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Applicable Codes:

36000	36410	36415	36591	36600	43752	43753	71045	71046
71047	71048	92953	93561	93562	94002	94003	94004	94660
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99291	99292	99466	99467	94760	94761	94762

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Applicable Codes:

99291	99292	99466	99467	99468	99469	99471	99472	99475
99476	99466	99477	99478	99479	99480			

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Medical Policy Z-34: Status of Patient vs. Place of Service

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-034		
Subject:	Prolonged Detention or Critical Care		
Effective Date:	May 7, 2018	**End Date:**	
Issue Date:	May 7, 2018		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☐	**1500** ☒		

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The terminology for critical care codes 99291 and 99292 specifies the codes and number of services billed for these services rendered by a physician must be reported using the actual amount of time spent with the patient.

Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E&M code.

Code 99291 is used to report the first 30-74 minutes of critical care on any given date. It should be used only once per date, even if the time spent by the physician is not continuous on that date. Reimbursement may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty.

Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date.

Critical care services of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes are not separately reported.

The service codes listed below are considered part of critical care services (codes 99291 and 99292) when performed on the same day, by the same critical care physician. When any of the services below are reported in addition to critical care, reimbursement for the service(s) is included in the reimbursement for the critical care codes 99291 and 99292.

Applicable Codes:

36000	36410	36415	36591	36600	43752	43753	71045	71046
71047	71048	92953	93561	93562	94002	94003	94004	94660
94662	94760	94761	94762	99090				

Note: Modifier 25 may be reported with medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 is reported, the patient's records must clearly document a separately identifiable medical care service was rendered.

Transportation of Critically Ill Patients

In cases involving either maternal or neonatal retrieval, the physician's attendance, while he or she personally renders care to the patient, should be reimbursed as prolonged detention or critical care.

Additionally, when it is medically necessary to transport a critically ill patient (inpatient or OP emergent) from one hospital to another more specialized hospital, the physician's attendance while he personally renders care to the patient will be reimbursed as prolonged detention or critical care.

Applicable Codes: 99291 99292 99466 99467 94760 94761 94762

Note: Payment may be made for 99291 when billed by different physicians in the same group practice, regardless of the physician's specialty. When modifier 25 is reported, the patient's records must clearly document that a separately identifiable medical care service was rendered.

Ventilator Management

Ventilator Management is applicable to patients of all ages, as well as neonates who are on respirators. Claims reporting only ventilator management will be reimbursed for those codes.

Applicable Codes: 94002 94003 94004 94660 94662

However, when critical care, pediatric critical care, pediatric critical care transport, neonatal critical care, or subsequent intensive care and ventilator management are reported on the same day by the same provider, the ventilator management service is included in the payment for the critical care and neonatal intensive care, with reimbursement being made for the critical care or neonatal intensive care, only.

Note: Modifiers 59, XE, XP, XS and XU may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifiers 59, XE, XP, XS and XU are reported, the patient's records must support its use in accordance with CPT guidelines.

Applicable Codes:

99291	99292	99466	99467	99468	99469	99471	99472	99475
99476	99466	99477	99478	99479	99480			

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Medical Policy Z-34: Status of Patient vs. Place of Service

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU