Critical Care Appendix

Other Critical Care Case Examples

Other Quick Hits

Critical Care Examples

- Psych
  - Consider CC
    - Delirium or organic cause identified plus ICU admit
    - Overdose requiring intervention and admission
  - Probably not CC
    - Overdose cleared in the emergency department for psychiatric assessment
    - Intoxicated awaiting sobering
    - Minor agitation/pure psych
    - Suicide assessment

Critical Care Examples

- Hypertension – new ICD-10 codes!
  - Consider CC
    - Hypertensive *emergency & crisis*
    - Both end organ damage, crisis rapidly rising
    - End organ(s) affected
      - Brain
      - Heart
      - Kidney
    - Treatment ongoing and typically ICU admit
  - Probably not CC
    - Hypertensive *urgency*
    - Incidental finding unrelated to main problem
    - May get PO or IV Rx but usually discharged or floor admit

Critical Care Examples

- Syncope
  - Consider CC
    - Syncope *plus* a significant co-morbidity. For example:
      - Arrhythmias such as new onset AF
      - Lower or UGI bleed
      - Significant hypovolemia
      - Altered mental status or seizure
      - Pulmonary embolism
      - Dispo: typically admit ICU
  - Probably not CC
    - “Weak and dizzy”
    - No significant co-morbidity
    - Simple faint

Critical Care Examples

- Seizures
  - Consider CC
    - Status epilepticus
    - Complex febrile seizure (peds)
    - Context of trauma, OD or ingestions
    - ETOH or drug withdrawal (delirium tremors)
  - Probably not CC
    - Recurrent with noncompliant or sub-therapeutic meds

Critical Care Examples

- Trauma
  - Consider CC
    - Hemodynamic instability/abnormal VS
    - Possible cord injury
    - Unresponsive/altered mental status
    - Penetrating trauma (gun shot, stabbing)
    - Procedures such as chest tube, intubation, central line
    - Dispo to OR or transfer to Trauma Center
  - Probably not CC
    - Mechanism alone in alert patient w/o complaints
    - Isolated extremity injuries w/o neurovascular compromise

Critical Care Examples

- Ingestions
  - Consider CC
    - High lethality agent requiring intervention or close monitoring
    - Seizures, coma, arrhythmias, hypotension
    - Active co-management with poison control
  - Probably not CC
    - Benign overdose with watchful waiting
- Severe allergic reactions
  - Consider CC
    - Stridor, wheezing. hypotension
    - IV epi or pressors
  - Probably not CC
    - Epipen in field and/or IV steroids and clears

Critical Care Examples

- Metabolic
  - Consider CC
    - Most admitted DKA and/or other metabolic acidosis admitted to ICU
    - Hyperosmolar states (e.g. coma)
    - Example dx: non-anion gap/anion gap metabolic acidosis, diabetic ketoacidosis, non-ketotic hyperosmolar coma, hyperthyroidism/thyroid storm, myxedema coma
  - Probably not CC
    - Mild DKA treated on floor or in ED and DC'd

Critical Care Examples

- Fluid and electrolyte abnormalities
  - Consider CC
    - Abnormal EKG
    - Symptomatic (e.g. confusion, muscle weakness)
    - Requires IV replacement treatment
    - Documentation of a critical value
      - Comment and/or treatment
    - Emergent dialysis required
    - Acute renal failure
    - Example dx: hyperkalemia, hypercalcemia

Critical Care Examples

- Environmental
  - Consider CC
    - Hypothermia: with aggressive re-warming
    - Lightening strike
    - CO with signs/symptoms requiring treatment, especially hyperbaric chamber

Critical Care Audits

Critical Care Audits

- Risk management/compliance approach. Consider reviewing:
  - CC >2 hours
  - Questionable medical necessity
  - High (and low) frequency providers
  - Common diagnosis
  - Importance of “Medical Necessity” note in questionable cases
  - Number of minutes and exclusion statement

Critical Care Documentation

When is it Critical Care?

Tricks of the Trade

When is it Critical Care

- May not be CC
  - Dispo: floor, tele, home
  - “NAD”
  - Normal VS
  - “Resting comfortably”
  - Minimally documented and/or benign ED Course that does not support medical necessity
  - Psychiatric cases
    - Maybe: high risk presentation with subsequent critical illness/injury, intense (medical) intervention

When is it Critical Care

- May not be CC (con't)
  - Urgent call and arrival of specialist is not CC unless substantial portion of workup and initiation of treatment by EP and time met
  - Abnormal lab values alone do not support CC unless MDM reflects high complexity MDM and initiation of life-saving assessment/treatment or prevention of serious deterioration

Consider Medical Necessity statement if above scenarios justify CC

Critical Care Documentation

"Medical Necessity" statement:

- "Organ system(s) at risk is…"
- Differential diagnosis
- "What and why" as far as diagnostic and/or therapeutic interventions undertaken by *YOU*
- Critical lab, imaging EKG findings documented and significance addressed
- ED Course reflects frequent re-assessments and decision-making
- Likelihood of life-threatening deterioration

Other Critical Care Conundrums

CC Conundrum Case: Pediatrics

- 6-month-old female presents to community ED triage with vomiting, diarrhea, and now not responding to parents well since this AM.
- Triage nurse notes patient is lethargic with glossy eyes and brings back immediately to ED and begins to search for IV access.
- POC glucose 36.
- ED physician notes patent airway, spontaneous respirations, delayed cap refill. Starts IO to administer IVF, glucose while referral center and flight called.

CC Conundrum Case: Pediatrics
The Clues are Different!

- Critical care same (99291, 99292)
- Typical cases
  - Fever/sepsis
  - Respiratory distress (status asthmaticus, bronchiolitis/RS etc)
  - SVT/congenital heart disease
  - Status epilepticus/complex febrile seizure
  - Abuse
  - COVID includes pneumonitis and MIS-C
- History heavily depend on non-patient sources

CC Conundrum Case: Pediatrics
The Clues are Different!

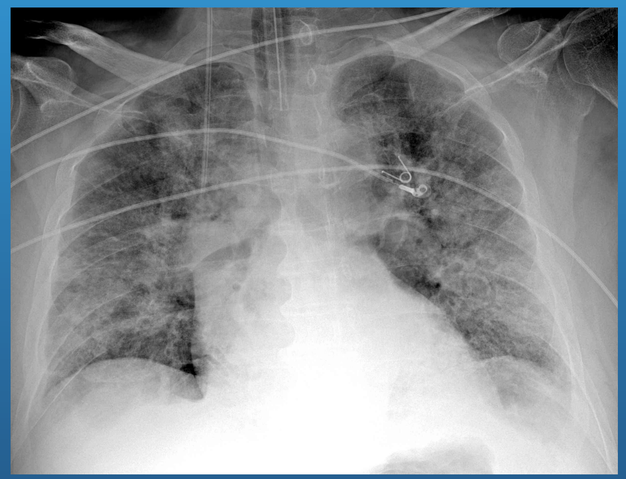
- Physical exam
  - General; alert and playful, cries on exam consoles normally
    - Severity: lethargic, not interactive, afraid of parent/adult
  - Cardiovascular; tachycardic
    - Severity: perfusion clues such as delayed capillary refill, mottled, altered mental status
  - Respiratory
    - Severity: nasal flaring, retractions, abdominal pushing, grunting
  - Skin; capillary refill, pink
    - Severity: delayed refill, gray/ashen, yellow/icteric, unexplained bruising
  - Neuro; non focal, normal for developmental age, walks normally to parent
    - Severity: focal findings, intermittent seizure activity

CC Conundrum Case: Pediatrics
The Clues are Different!

- Evaluation and interventions may be limited, but support severity of illness:
  - IV/IO
  - High flow oxygen, end tidal CO2, bipap, intubation
  - IV fluid boluses, antibiotics, drips
  - XR, glucose check, basic labs-pending
  - Transfer early

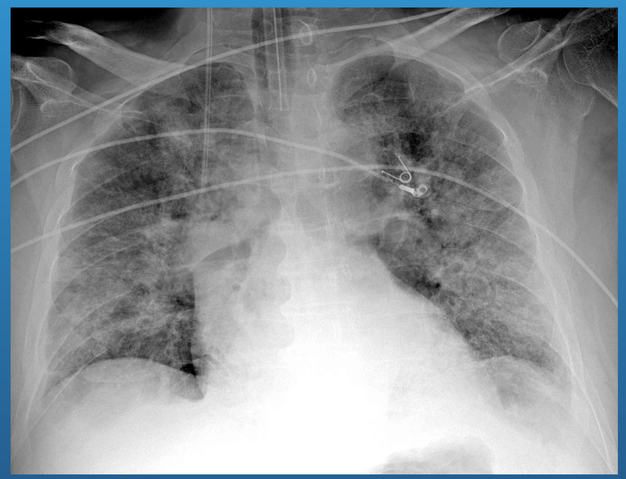
CC Conundrum Case: Labs Normal

- 54 yo man walks into ED Triage complaining of profound fatigue, weakness and cough for a week.
- Has been walking back and forth across the border for the last 3 weeks, receiving zpack and inhaler from pharmacist, but getting worse.
- Vital signs:
  - 120
  - 80
  - 82
  - 32
  - 78



CC COVID Conundrum Case: Labs Normal

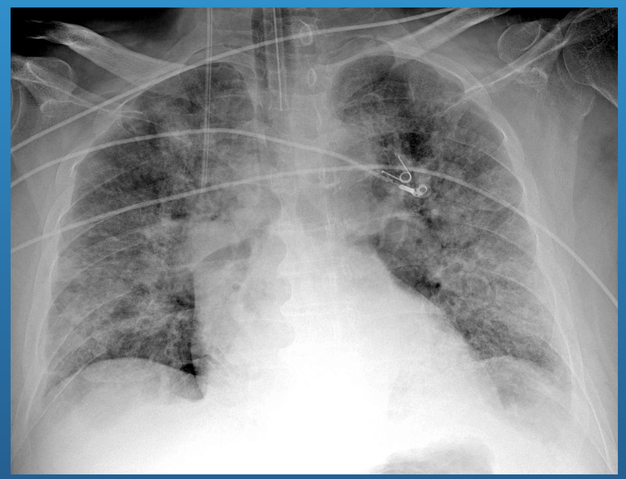
- Vital signs:
  - 120/80 blood pressure
  - 82 pulse
  - 32 respiratory rate
  - 78% pulse ox
- CBC normal, CMP normal, lactic acid normal, ABG normal other than profound hypoxia
- Chart shows interventions: steroids, High Flow Nasal Cannula (HFNC), inhalers, eventually bipap and then intubation
- ”I provided 60 minutes of critical care time, exclusive of separately billed procedures.”
- One test positive…



CC COVID Conundrum Case: Labs Normal

- One test positive…COVID

- Key concepts:
  - Happy hypoxic
  - Normal VS and labs except hypoxia
  - Abnormal CXR
  - HFNC game changer



CC Time Conundrum Case: EMS ST Elevation MI

- EMS calls with 72-year-old male patient en route with chest pain. 20-minute ETA.
- Pre arrival ECG sent and shows ST elevation MI.
- Cath lab team activated pre arrival.
- After 15 minutes patient leaves department to cath lab.
- Does patient meet 30-minute threshold for critical care? NO

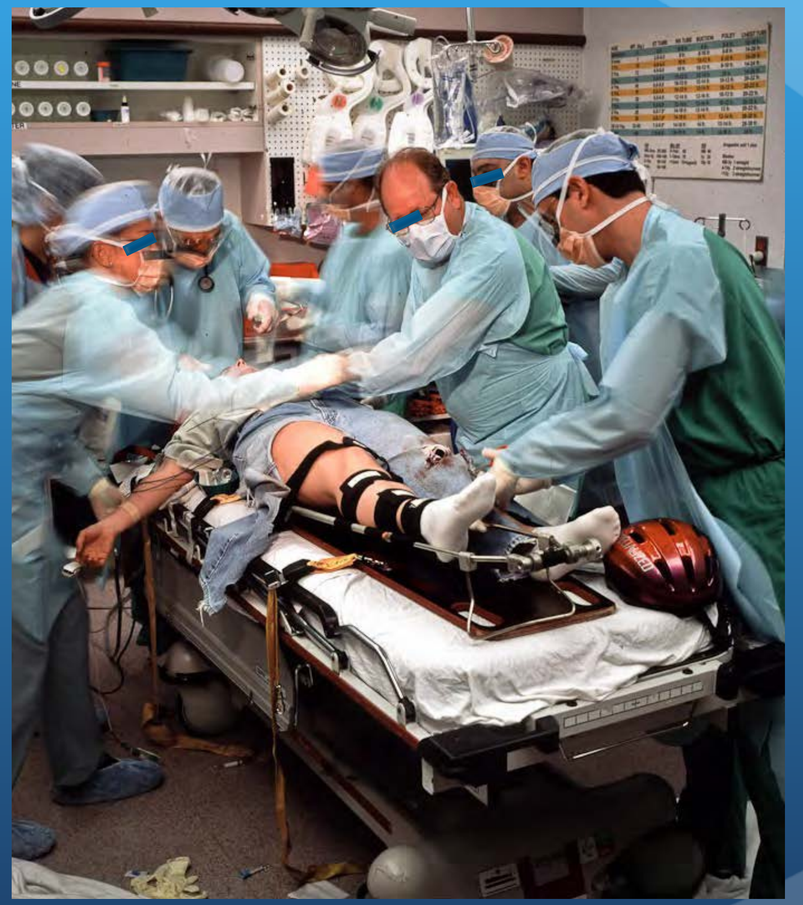
CC Time Conundrum Case: EMS ST Elevation MI

Presence of physician or APP

- CMS and CPT agree:
  - MLN Matters Number: MM5993 Revised: *Time spent off the unit or floor where the critically ill/injured patient is located (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care time because the physician is not immediately available to the patient. This time is regarded as pre- and post service work bundled in evaluation and management services.*

Controversy case:
Level 1 Trauma Activation

- 22-year-old female in high velocity MVA, ejected from the vehicle.
- Obvious femur fracture, confused and combative with major contusions to head/face.
- Level 1 trauma team OA.
- ED physician manages airway with supplemental O2, opens airway, maintains c-spine.
- Trauma surgeon starts CVP, assess hypotension, orders meds, bedside US, transfuses blood.
- Who bills for critical care? BOTH



Controversy case:
Level 1 Trauma Activation

Trauma Team activation -

2022 CMS Physician Fee Schedule - ”CC Visits Furnished Concurrently by Different Specialties”

- **May be furnished by more than one practitioner…if the service meets definition of CC and is not duplicative of other services**
- **“…medically reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”***

**2022 CMS Physician Fee Schedule*

Controversy case: Time Spent with Family

- Time spent speaking with family members or surrogate decision-makers counts if:
  - The patient is unable or incompetent to participate in giving history and/or making treatment decisions;
  - Obtaining a history, reviewing the patient's condition or prognosis or discussing treatment or limitation(s) of treatment
  - "provided the conversation bears directly on the management of the patient"
  - A summary in the medical record that supports this medical necessity.

Controversy case: Time Spent with Family

- 90-year-old female history of lung cancer on chemotherapy with fever, cough, pneumonia, sepsis.
- Patient confused, septic, and does not want antibiotics or fluids. Just wants to go home.
- 50-year-old son, the POA, arrives, you pull him aside and ask about her history, update him on labs and treatment. He gives permission to treat.
- Can you count your conversation with son towards critical care time? YES

CC Time Conundrums: Past Midnight

- Scenario 1: How would you code a patient who presents to the ED at 2335 Day 1, with CC services beginning at that time and performed continuously until 0015 on Day 2, with no more CC services performed on Day 2?

  Answer: Critical care 99291 for Day 1.

- Scenario 2: How would you code a patient who presents to the ED at 2335 Day 1, with CC services beginning at that time and performed continuously until 0015 on Day 2, at which time continuous CC services are interrupted; CC services are reinitiated at 0130 Day 2, with an additional 65 minutes provided on Day 2 following the re-initiation?

  Answer: Critical care 99291 for Day 1, 99291 for Day 2.

CC Conundrum: can 9928X followed by CC be reported together?

- Patient presents with chest pain and has a 99285 service provided. Patient admitted to hospital. While waiting for a bed he has an episode of hypotension and run of ventricular tachycardia. 99291 critical care criteria met.
  - CPT: May report 9928x plus 99291 by same physician on same calendar day
  - 2022 CMS: now agrees, with -25 modifier

CC Conundrum: can CC followed by 9928x be reported together?

- CPT: Yes
- CMS: No

Critical Care & Procedures

CC Time: Procedures Bundled

The following services are included in critical care time, not reported separately:

- Interpretation of cardiac output (93598)
- Chest x-rays, professional component (71045, 71046)
- Blood gases, information stored on computers (e.g. ECGs, blood pressures, hematologic data)
- Gastric intubation (43752, 91105)
- Pulse oximetry (94760, 94761, 94762)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94002-94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36591, 36600)

CC Time: Procedures Unbundled

- Time spent performing *unbundled* procedures is not considered as counting toward CC time
- Unbundled procedures are separately billed
- Examples
  - Wound repair
  - Intubation
  - Chest tubes
  - Central lines
  - CPR
- 2022 CMS: add modifier FT for unrelated E/M visit and global procedures

CC Time Documentation: Procedures

- Recommended that the physician note that separately billed procedure time was not included in CC time
  - "the time involved in the performance of separately reportable procedures was not counted toward critical care time" or
  - "exclusive of separately billed procedures"
  - To avoid reduction of time by payers