

**Critical Care Coding**  
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**Critical Care Documentation**

Three distinct criteria that must be documented in the ED chart.



- ✓ Critical Condition
- ✓ Critical Intervention
- ✓ Time

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**Critical Care Documentation**

Critical Condition

- A critical illness or injury acutely impairs one or more vital organ systems.
- High probability of imminent or life-threatening deterioration .

Some degree of subjectivity for “high probability of deterioration”

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## Common Critical Conditions



- Respiratory failure or circulatory failure.
- Organ system which has failed or is failing.
- Significantly abnormal vital signs.
- Shock.
- Acidosis.
- Need for interventions such as central venous access, thoracostomy, transfusion of blood, cardioversion/defibrillation, "ACLS" type IV medications.
- Trauma patients with serious injuries.
- Patients requiring ICU admission.

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## Critical Care Documentation



### Critical Intervention

- It is necessary to have done something for the patient.
- Interventions that withdrawal of or failure to initiate would likely result in sudden clinically significant or life-threatening deterioration.



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## Critical Care Documentation



- Heroic life-saving measures are easier to identify.
- CPT seems to allow complex decision-making as meeting this requirement.
- More justifiable with a identifiable intervention which averted or treated the patient's actual or potential deterioration.

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## Critical Care Documentation



### Time

- The physicians total time spent performing critical care must be clearly documented.

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## Critical Care Time



- Time was exclusively devoted to the patient.
- Does not have to be continuous.
- Does not have to be at bedside.
- Must document that time involved in separately billable procedures was not counted toward CC time
  - *I provided X minutes of critical care outside of separately billable procedures*

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## Critical Care: The Math



- 99285
  - MI RVUs = 4.83
- 99291
  - MI RVUs = 7.51

**Critical Care is a 30% increase in RVUs!!**

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## Chest Pain



This is a 64-year-old female with chest pain and associated symptoms and history of CAD, concerning for ACS. First priority will be to get the patient pain-free. Will order labs and portable chest. D-dimer negative (patient was a little tacky and O2 was down to 91 when sleeping after morphine, placed on O2), think PE was unlikely to begin with and now highly unlikely given negative test result.

Chest x-ray does show a questionable widened mediastinum, so repeated with the two view which shows the same. Will get CTA as o/w she needs heparin. Called the lab to rush troponin results, came back positive at 4.5 consistent with STEMI / ACS.

Patient is now pain-free and sleeping after ASA, morphine and nitro. Discussed the case, labs and EKG with cardiologist on call. She recommends transfer to tertiary care facility where patient will have the option for immediate catheterization overnight if pain returns.

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## Chest Pain



I discussed with XXX and they had excepted. Family and patient agrees with plan as well.

CTA negative, results came back just as ambulance here for transfer, starting heparin now just prior to transfer. Patient did vomit the IV contrast but has no chest pain and nausea. Is pain-free at this time.

Being transferred via ALS to XXX.

Diagnosis acute coronary syndrome/chest pain

Total critical care time 37 minutes.

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## Wide complex tachycardia



52 year old present with palpitations. Initial EKG showed wide complex tachycardia with rate of 170. Pt treated with electrical cardioversion.

### Medical Decision Making

**Differential Diagnosis:** Angina, atypical chest pain, dysrhythmia, afb/brv, svt, vtach.

**Rationale:** Pt presents with palpitations, weakness. Had CP earlier today. Called into room to eval emergently due to HR 170. On monitor, appeared to have either a wide complex tachycardia or narrow complex with wide T waves. It was unclear. EKG was read as narrow complex with wide T waves. EKG did read ACUTE MI but patient was not having CP and his HR was 170 which is likely why he had the ST changes. He is on an antiarrhythmic and a beta blocker for intermittent AFib. Was cardioverted a month ago as well. Is on pradaxa for anticoagulation.

Pt was stable and talking on arrival with normal BP, just elevated HR. I suspected the EKG represented an SVT but could not be sure it was not VTach. Therefore, decision made to emergently cardiovert. Pt sedated with 100 mcg Fentanyl and 2 mg Versed and achieved good sedation. Then cardioverted at 120 J synchronized. Considered using Amiodarone as well but after one shock patient is in NSR with rate of 50 and amio not needed.

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## Anemia with Sepsis



62 year old with anemia, hypotension and sepsis. Patient treated with fluid bolus and Norepinephrine infusion. Chest x-ray shows questionable small left pleural fusion versus infiltrate. Central line is in good position.

Blood cultures are pending. WBC is 13.1, hematocrit is 21.6 with a platelet count of 148.

Nursing reports that the blood bank called stating the patient has 2 to 3 antibodies and so there will not be any blood available for at least 2 to 3 hours for transfusion. She does have a neutrophil count of 91.9% BUN is 36, Crit is 2.3. Previous values a couple days ago were 29 and 2. The rest of the chemistries unremarkable except for calcium of 7.7. BNP is slightly elevated at 89. Lactic acid is normal at one. Magnesium is 1.5.

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## Anemia with Sepsis



Patient received 500 ML fluid bolus, but still has blood pressure in the 70s. Therefore a central line was placed and Norepinephrine was started. Her urine and urine cultures are also pending, but she has not had any urine output through her Foley catheter.

Case discussed with the family and ICU resident was notified. The patient will be admitted to the ICU on the Norepinephrine.

Critical care time 60 minutes

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## Hip fracture



Patient is an 80-year-old woman who presents to the hospital with left hip pain after fall. She reports she needed to go to the bathroom. She was unable to make it from the bed to the bathroom and started to urinate.

She then slipped and fell on her left side. She has left hip pain. If she is unable to move her leg. She denies any head injury or loss of consciousness. She denies any chest pain or palpitations.

She was recently admitted to the hospital for urosepsis abdominal pain.

X-ray shows evidence of a fracture. She will be admitted to the hospital for definitive repair.

Critical care time 30 minutes

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## DKA



36 year old with elevated blood sugars and lethargy for 2 days. Blood work shows metabolic acidosis and blood sugar of 635. Pt. treated with Insulin drip and aggressive fluid management.

MDM  
Hyperglycemia, r/o DKA  
Initially started with IVF resuscitation with NS bolus x2L  
Glucose >500, Insulin IV 0.15 units/kg ordered  
CMP with AG 18, low bicarb. Confirmed with >80 ketones in urine (not infected) and blood gas with pH 7.10--DKA  
Patient's HR improving with IVF  
Litters 3 and 4 ordered  
Insulin drip at 0.10 units/kg  
BS already downtrending with fluids and bolus--now 400  
Admit to SCU  
**Clinical Impression**

1. Diabetic ketoacidosis without coma associated with type 2 diabetes mellitus

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## Allergic reaction



22 year old presented in acute anaphylaxis with hypotension and tongue swelling. Treated with IV fluids, Epi and steroids.

**EMERGENCY DEPARTMENT COURSE:** This appears to be acute anaphylaxis. We proceeded with epinephrine along with steroids and intravenous (IV) resuscitation. The initial blood pressure is in the 70s, initially systolic. With this, the patient starts to improve. Electrocardiogram shows sinus tachycardia with occasional premature atrial contractions (PAC). There are no acute ischemic changes  
  
With careful monitoring and IV running, his blood pressure comes up nicely and his tongue on serial exam, the swelling comes down and he is able to talk. The patient notes that he has been using methamphetamine last night and then again this morning. He notes that he had polluted up some water and Clorox to scrub some toilets and after this he started having symptoms. I questioned him rather closely about the concomitant use of drugs and he is rather evasive about this.  
  
**CRITICAL CARE TIME:** I spend with this patient one hour.  
  
**IMPRESSION:**  
1. Acute anaphylaxis.  
2. Acute methamphetamine abuse.

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## Acute MI to Cath lab



This is a 76-year-old male with substernal chest pain. EKG shows STEMI with elevation in V2 and V3. STEMI team was activated. Patient given ASA, and heparin and taken to the Cath Lab.

Critical care time approximately 15 minutes.

Due to the severity the patient's condition I was I unable to complete a comprehensive history exam due to the need for immediate cardiac catheterization.

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## Feel Free to Contact Us



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