

Charting Pearls

Documentation tips for using The T System

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Critical Care: Proper documentation is critical

Critically ill patients are cared for in virtually every emergency department in the U.S. on a fairly regular basis. This is not, however, generally reflected in the frequency of use of the Critical Care (CC) codes. One reason for the discrepancy is that the documentation requirements for CC are somewhat subjective and can be rather confusing. This installment of Charting Pearls will try to simplify the documentation requirements, and supply useful examples of when CC should be considered.

Definition

CC services (CPT® codes 99291- 99292) are defined as the direct delivery by a physician of medical care for a critically ill or injured patient. A critical illness or injury is a condition that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. CC involves high complexity medical decision making to assess, manipulate, and support vital system functions to treat single or multiple vital organ system failure, and/or to prevent further life-threatening deterioration of the patient's condition.

Documentation

To justify CC, three essential elements must be clearly documented by the physician. These elements are: nature of the critical illness, interventions required to treat and/or stabilize the patient, and time involved in direct care of the critically ill patient.



Nature

Nature of the critical illness infers “medical necessity,” which must be thoroughly supported by the physician's documentation. The physician should clearly document all positive or abnormal physical findings, especially abnormal vital signs, and any positive or abnormal test results used in the medical decision making process to determine the need for CC interventions. Most importantly, the Clinical Impression should reflect the critical nature of the patient's condition, and is usually looked at first in determining “medical necessity.” Clinical Impressions that may support the use of CC include, but are not limited to:

Acute Abdominal Aneurysm, Acute Coronary Syndrome (AMI or Unstable Angina), Altered Mental Status (especially Comatose/Unconscious), Aortic Dissection, Arterial Occlusion, Asthma (Status), Atrial Fibrillation with a Rapid Ventricular Response, Bradycardia (Symptomatic), Cardiac Arrest, Cardiac Tamponade, Cervical Spine Fracture, CHF/ Pulmonary Edema (Acute/Severe), COPD (Acute Exacerbation), DKA, Drug Overdose, Dysrhythmias (e.g. VT, VF, 3rd Degree Block), Ectopic Pregnancy, Epidural Abscess, Esophageal Perforation, Fractures (Open), GI Bleed (Acute), Head Injury (Severe/Unresponsive), Hypertensive Emergency, Hyper/Hypothermia, Intracranial Hemorrhage (e.g. Epidural, Intracerebral, Subarachnoid, Subdural), Mesenteric Ischemia, Metabolic Disorders (Severe) (e.g. Acidosis, Hyper/Hypocalcemia, Hyper/Hypokalemia, Hyper/Hyponatremia), MVC/Multiple Trauma (especially with AMS and/or Abnormal Vital Signs), Neonatal Fever (<29 Days Old), Pneumonia (Severe), Pneumothorax, Pre-eclampsia/Eclampsia, Pulmonary Embolism, Renal Failure (Acute), Respiratory Failure, Seizure (Status), Sepsis, Shock (Anaphylactic, Hemorrhagic, Hypovolemic, Neurogenic, Septic), Stroke/CVA, Suicidal Attempt/Ideation (Serious).

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Interventions

Clearly documenting the interventions required to treat and/or stabilize a critical patient is perhaps the best and easiest way to justify the life threatening nature of the patient's presentation. Interventions that support the use of CC services include not only procedures, but also the use of certain drugs, particularly resuscitative drugs and IV infusions (i.e. drips), and the patient's transition/transfer to higher level of care. A chronology of the interventions performed and the patient's response, and/or changes in the patient's condition should be documented in the Progress section of the template. An Add-on template (e.g. Critical Care/Trauma – 23a) may be required if multiple procedures are performed or if more space is required for additional progress notes. Examples of interventions that may help support the use of CC include, but are not limited to:

Admission to an Intensive Care Unit, Antidote Administration (for Drug Overdose), Arterial Line Placement, Cardioversion/Defibrillation, Chest Tube Placement, Central Line Placement, CPR, Cooling/Warming Techniques (for Hyper/Hypothermia), Emergency Surgery, Endotracheal Intubation (or BiPAP/CPAP to Avoid Intubation), Fluid Boluses (for Hypotension), Gastric Lavage, Infusion Therapy (e.g. Diltiazem, Dobutamine, Dopamine, Epinephrine, Esmolol, Glucose, Heparin, Insulin, Magnesium, Nitroglycerin, Nitroprusside, Norepinephrine, Propofol), Intravenous Drugs for Resuscitation (e.g. Amiodorone, Atropine, Epinephrine, Lidocaine, Magnesium, Procainamide, Vasopressin) Multiple Consults, Pacemaker Placement/Use -Transcutaneous or Transvenous, Restraints (Chemical and/or Physical), Thrombolytic Therapy (for AMI, Stroke or Pulmonary Embolism), Transfer to a Higher Level of Care Facility, Transfusion (PRBCs, Platelets, FFP, etc.).

Note: CC should be considered in a patient requiring any of the above interventions.

Time

Time is the easiest to document, yet perhaps the most confusing and most forgotten of the documentation requirements

for CC. The physician must document the total time devoted exclusively to the care of the critical patient. CC time can be continuous or interrupted, and includes time spent at the bedside in direct patient care (i.e. initial assessment and re-assessments) as well as time spent reviewing lab results and imaging studies, discussing the patient's care with other medical staff or ancillary staff, obtaining medical history and/or discussing treatment options with family/caregiver(s) (i.e. when the patient is unable to provide history or make treatment decisions), reviewing old records, documenting in the medical record, and performing certain procedures or services (e.g. gastric intubation, peripheral vascular access, transcutaneous pacing, ventilator management) that are not "separately billable." Note: most of the commonly performed CC procedures (e.g. arterial line placement, central line placement, chest tube placement, CPR, endotracheal intubation) are "separately billable," and the time it takes to perform these procedures must be subtracted from the total CC time. A minimum of 30 min is required in order to bill for CC services (CPT code 99291 is used for 30-74 min, 99292 is added for 75 min plus). The total time in minutes spent on CC should be documented at the end of the Progress section:

CRIT CARE TIME (excluding separately billable procedures) ___ min.

Note: *the physician must document the total time involved in the delivery of CC services; (it cannot simply be inferred and extracted from the record.*

There is a significant financial benefit to coding for CC compared to even the highest E/M code (i.e. level 5 - 99285). When a patient meets the level of medical necessity that warrants consideration of CC, the physician should document the patient encounter as completely as possible, including the total time dedicated to the care of the patient (i.e. excluding time spent on "separately billable" procedures as noted above), and let the coders decide how best to code the patient encounter. For those that would like more detail concerning CC services, or for those that supervise residents and/or mid-level practitioners, please visit the CMS website <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5993.pdf> for a more complete description of the coding requirements.

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