LogixHealth’s unsurpassed service stems from the fact that our founders’ own medical practices are customers.
In the last several years, the definition of critical care has been changed several times. Initially, patients had to be frankly unstable and then potentially unstable. Importantly, the CPT definition for critical care now simply states that “there is a high probability of imminent deterioration in the patient’s condition.” This redefining of critical care allows additional patients to meet the criteria of “critical care.” Patients now typically qualifying for critical care frequently include:

- Chest pain patients requiring nitroglycerin, and those with EKG changes, ACS, or acute MI
- Dyspnea patients requiring aggressive interventions such as multiple nebulizer treatments, high flow oxygen and close monitoring, with a clinical condition such as severe asthma, pneumonia, and CHF
- Severe metabolic derangements such as DKA, dehydration, or renal failure

Of note, you can see from the above examples that there is not a clinical requirement for pressors, intubation, or invasive monitoring.

Keep in mind that in addition to meeting the definition of “having a critical illness or injury,” the physician must also deliver 30 minutes of critical care outside of separately billable procedures. These sicker patients frequently require 30 minutes of physician care. Time counting towards the 30 minutes includes:

- Direct bedside care of the patient
- Interpretation of lab and radiology studies
- Gathering history from family, EMS, and old records
- Discussion of the patient’s case with other physicians
- Time spent documenting the record
- Time spent performing bundled procedures such as reading chest x-rays, interpreting pulse oximetry, blood draws, and insertion of peripheral IV’s

Keep critical care in mind when you are treating a sick patient. Alert the coder that you feel you have met the requirements for critical care by stating: “I have delivered 30 minutes of critical care.”

**Diagnosis Pearl**

Critical care patients frequently have multiple procedures performed. Make sure you have a distinct diagnosis code to support each procedure. For instance, a multiple trauma patient requiring intubation, a chest tube, a central line, and repair of a facial laceration could have these extensive services supported by the following code pairs:

Critical Care: Dx Closed head injury
Intubation: Dx Respiratory failure
Chest Tube: Dx Pneumothorax
Central Line: Dx Hypotension, tachycardia
Laceration Repair: Dx Facial laceration
**Case #1:** A 40 year old female is brought to the ED with SVT. HR is 190, BP 100/60. She is complaining of chest pain, dyspnea, and appears in distress. The physician considers electrical cardioversion, but feels a quick attempt at chemical conversion with adenosine is warranted. After a second dose of 12mg of adenosine the patient converts to sinus tachycardia. She is observed on the monitor. Labs are normal. The physician performs several repeat assessments, as well as a follow-up EKG, and ultimately she is discharged. The physician states that 30 minutes of critical care was delivered, including time devoted to direct management of the patient, multiple bedside assessments, review of the labs, a discussion to arrange close follow-up with the PMD, and documenting the record.

**Does this discharged patient qualify for critical care?**
The physician felt that the patient met the criteria for "imminent danger of deterioration," which is a clinical judgment that seems reasonable.

**But the patient was discharged?**
Although the majority of critical care patients will be admitted to an ICU, clinical care does not require an ICU admission and discharging the patient does not preclude using critical care. Other common clinical presentations that may qualify for critical care, but are ultimately safely dischargeable include certain allergic reactions and seizures.

**Case #2:** A 55 year old male presents to the ED complaining of 7/10 chest pain. Past history is significant for hypertension and his blood pressure in the ED is 205/117. He has had no previous cardiac evaluation. Initial EKG shows ST depression. He is given aspirin and his chest pain is sequentially relieved after 3 sublingual nitroglycerin tablets. Cardiac enzymes are normal. Once his chest pain is relieved, he receives additional treatment with nitro paste and anticoagulation.

**This patient didn’t seem to be having an acute MI. Does he qualify for critical care?**
Based on the risk factors, the nature of the presenting problem, and the treatment that was required to stabilize his chest pain, the physician demonstrated that he felt that the patient was in "imminent danger of deterioration."

**Case #3:** A 2 year old is brought to the ED with a croupy cough, a respiratory rate of 40, and a low grade temperature. The physician notes significant stridor when the child is crying and concerning stridor and tachypnea at rest. The child is treated with an intramuscular dose of decadron and a racemic epi nebulizer treatment. Following the racemic epi nebulizer treatment the child remains tachypneic, but is more comfortable. The physician performs several repeat assessments over the next few hours and also interprets a CXR as normal. Several hours later the child is discharged with a diagnosis of croup, fever, and tachypnea. This case is an example that demonstrates the requirements for critical care are a patient in "imminent danger of deterioration" and 30 minutes of physician care being provided, and that there is not necessarily a requirement for admission, intravenous medications, or extensive diagnostic studies.

**Reimbursement Pearl**

Increasing your critical care by just 2% yields over $45,000 in collectible money for a 45,000 visit ED.

45,000 x .02 = 900 patients per year

Reimbursement gain moving from 99285 to 99291: $50

900 patients x $50/patient = $45,000
What procedures may be billed in addition to critical care?
Common procedures billed in addition to critical care are intubation, central venous access, chest tube, pericardiocentesis, transvenous pacemaker placement, CPR and EKGs. Remember to subtract out the time spent performing separately billed procedures from your critical care time.

I understand you need to satisfy the requirement for 30 minutes of physician work to report critical care. What if I deliver much more than 30 minutes?
CPT allows us to report critical care in various time increments. The first hour actually runs from 30-74 minutes. See table.

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Report</th>
</tr>
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<tbody>
<tr>
<td>30-74</td>
<td>99291</td>
</tr>
<tr>
<td>75-104</td>
<td>99291 &amp; 99292</td>
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<tr>
<td>105-134</td>
<td>99291 &amp; 99292 x2</td>
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<tr>
<td>135-164</td>
<td>99291 &amp; 99292 x3</td>
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What are the documentation requirements for critical care? Are they similar to the requirements for the regular ED codes 99281-99285?
While Medicare has strict bullet counting documentation requirements, for ED E/M codes 99281-99285, as described in the 1995 Documentation Guidelines, the same criteria are not applied to critical care. Critical care is the major time based code used in the ED. The chart should reflect and support that the patient’s condition was “critical” and that a minimum of 30 minutes of care was delivered. The typical requirements for HPI, ROS, and other documentation elements do not apply.

What is a good benchmark for the amount of critical care we should be billing?
This varies based on the acuity of the practice. Practice parameters which generally support a higher reporting of critical care services include, tertiary care referral facilities, trauma centers, higher percent of Medicare patients, and more patients arriving by ambulance.

Procedure Pearl

Remember it is the physician oversight of CPR that allows for the reporting of CPR services. For example, the physician does not have to personally perform chest compressions.
LogixHealth’s state-of-the-art data warehouse continuously monitors coding distributions and provides productivity, outlier and RVU reports.