Critical Care: The Forgotten Code

I. Critical Care: CPT Definition

Critical care is the care of the unstable critically ill or unstable critically injured patient who requires constant physician attendance. The physician need not be constantly at the bedside, but must be engaged in the work directly related to the individual patient’s care, such as interpretation of EKG’s, x-rays, lab results, and coordination of patient’s care with other care providers.

A. Emergency Department Physicians were surveyed to estimate the percentage of patients they see to whom they provide critical care. The estimates always range over 5% and sometimes approach 10%. Yet in coding utilization analyses, critical care codes represent only about 1% of the Emergency Department visits. Clearly there is a documentation shortfall.

II. What constitutes critical care?

A. CMS defines critical care as “The failure to initiate treatment on an urgent basis would likely result in sudden, clinically significant life-threatening deterioration in the patient’s condition.

B. Critical care services are provided but not limited to patients with:

1. Central Nervous system failure (CVA, AMS)
2. Circulatory failure
3. Shock-like conditions
4. Renal failure
5. Hepatic failure
6. Respiratory failure
7. Post-op complications
8. Overwhelming infection (sepsis)
9. Multiple trauma

III. Determining time spent in critical care

A. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient’s care, whether that time was spent at the immediate bedside or elsewhere on the floor or unit. For example:

1. time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies
2. discussing the critically ill patient’s care with other medical staff
3. documenting critical care services in the medical record
4. also, when the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or
surrogate decision makers obtaining a medical history, reviewing patient’s condition or prognosis, or discussing treatment options.

B. Critical care codes are used to report the total duration of time spent by the physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous.

5. A physician does not have to spend 30 minutes of continuous time on a critical patient but can total the time segments he has spent with or on the care of the patient.

6. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

IV. Documenting critical care

   A. Critical care time must be documented by the physician. The coder cannot put a critical care code on a chart without two key phrases made by the physician.

   1. The amount of time in minutes spent in critical care.

   2. Physician must note that the patient was “unstable” or “critical.”

   B. Critical care does not require the HPI, ROS, PFSH, and physical exam elements that regular E&M codes do. The physician need not worry about these because of the seriousness of the patient’s condition.

   3. Time Documentation

      | Critical care time | Code                  |
      |--------------------|-----------------------|
      | Less than 30 minutes | 99284 or 99285          |
      | 31-74 minutes       | 99291 (Critical Care – first hour) |
      | 75-104 minutes or more | 99291 (each ½ hour) |

V. Pediatric critical care

   A. Same guidelines apply as in regular critical care. The physician need only document the time spent providing critical care services and that the patient is “unstable” or “critical.”

VI. Procedures included in critical care

   A. The following is a list of procedures that are included in the critical care time. Anytime spent on these procedures should be added into your number of minutes spent providing critical care.

   1. Cardiac output measurements interpretations
   2. Chest x-rays
   3. Blood gases
   4. Gastric intubation
   5. Temporary transcutaneous pacing
   6. Ventilator management
7. Vascular access procedures
8. Accessing computer data files
9. Pulse oximetry

VII. Procedures NOT included in critical care
   A. The following is a list of procedures that are commonly performed on patients in a critical condition. They are not included in the critical care code and should be billed separately. The amount of time spent performing these procedures should be deducted from the total critical care time.
   1. CPR
   2. Endotracheal intubation
   3. TPA administration
   4. Prehospital control
   5. Central line placement
   6. Wound repairs
   7. Laryngoscope
   8. Thoracentesis/Thoracostomy

   B. Any other procedures performed that are not listed in the procedures included in critical care section should be reported separately. The time spent on these procedures should not be added into your total critical care time.

VIII. What critical care is not
   A. Critical care codes are often misused as codes to recognize a doctor’s amount of time spent with a particular patient. The common illustration is the patient who presents intoxicated and requires a long stay in the ED to recover. The doctor may spend a significant amount of time with this patient but he is not in a life-threatening situation. Obviously critical care would not apply in this case.
   B. To qualify for the critical care you need not only an amount of time spent on a patient but the patient must be unstable or in critical condition. The imminent danger to a patient’s life if the physician were not to intervene must be the driving factor of critical care. Otherwise an E&M level is appropriate.

IX. FAQ’s about critical care
   1. Q. Can a critical care patient be discharged home?
      A. Yes, there are some cases where a patient may present with a life-threatening condition but after intervention can feel well enough to go home. Common clinical scenarios for critical patients who are discharged home include anaphylaxis, an asthma patient suffering an acute attack, angioedema, SVT, and sometimes even congestive heart failure. As long as the
physician’s work meets the definition of critical care, there is no requirement that a patient be admitted.

2. Q. Can a physician charge for critical care outside of the ED?
   A. Yes, there are instances when a physician is called to another wing of a hospital to help with a patient in severe distress, where the critical care is performed is irrelevant as long as the requirements for critical care are still being met.

3. Q. Does the physician have to be at the patient’s bedside the entire time that critical care is being reported?
   A. No, but he must be doing work that directly relates to the patient.

4. Q. Can a physician see more than one patient while he is treating the critical care patient?
   A. Yes, critical care time does not have to be continuous so the physician can treat another patient as long as he is not counting the time spent on that patient towards his critical care time. Then he can again see to the critical care patient and start the critical care clock again.

Example: Two patients come into the emergency department with life-threatening illnesses. They are both under the same doctor’s care for 55 minutes. He treats both of them under the critical care standards, however there is not enough time to charge critical care for both patients as you have to have 31 minutes to charge critical care (99291) under CPT guidelines. The second patient can only receive an E&M level of service.

X. Clinical examples of Critical care services

1. First hour of critical care of a 65-year-old man with septic shock following relief of ureteral obstruction caused by a stone.
2. First hour of critical care of a 15-year-old with acute respiratory failure from asthma.
3. First hour of critical care of a 45-year-old who sustained a liver laceration, cerebral hematoma, flailed chest, and pulmonary contusion after being struck by an automobile.
4. First hour of critical care of a 65-year-old woman who, following a hysterectomy, suffered a cardiac arrest associated with a pulmonary embolus.
5. First hour of critical care of a 6-month-old with hypovolemic shock secondary to diarrhea and dehydration.
6. First hour of critical care of a 3-year-old with respiratory failure secondary to pneumocystis carinii pneumonia.