C.F.R.

Clinical Financial Resource, Inc.

CRITICAL CARE DOCUMENTATION TIPS

Abbreviated definition of Critical Care

Critical Care is the direct care by the physician or MLP for a patient with a high probability of imminent or life threatening deterioration in their condition. The physician makes complex decisions to assess, manipulate and support vital system function to treat organ system failure and/or to prevent further life threatening deterioration. Medicare states that in order to qualify as critical care, "the failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition".

Documentation Requirements:

1. Documentation that Critical Care was provided.
2. Documentation of a minimum of 30 minutes of critical care in direct patient care (including time with patient, obtaining history from family, reviewing records and tests, discussing with other physicians; excluding otherwise speaking with family and time spent on other billable procedures).
3. Documentation in the record that reflects the patient was critically ill or injured.

Clinical Presentations Consistent with Critical Care

Unstable vital signs

- Hypotension, systolic blood pressure less than 90mm Hg, hypovolemic,
- neurogenic or vasogenic shock
- Septic shock
- Hypertension, systolic blood pressure greater than 190mm Hg
- Catecholamine crisis
- Heart rate greater than 140 or less than 50
- Severe arrhythmias- therapy such as Lidocaine, Bretylium, Inderal, or Verapamil,
- Adenocard or vasopressors

Respiratory Distress

May require airway intervention, intensive pharmacologic management

- Pneumothorax
- pulmonary edema

- COPD/Asthma
- Severe allergic reactions or croup

Chest Pain

EKG changes treated actively; use of Intravenous meds- Nitroglycerin, Integrillin, Beta Blockers

- Acute MI Cardiac tamponade
- Unstable Angina

Activities not included in critical care time

• Time off the unit, discussing the patient or giving orders by phone
• Discussions with the patient's family for the purpose of informing them about the patient's condition.
• Performing procedures not bundled into critical care services.
• Providing services to any other patients

Activities included in critical care time – not billable separately

According to the transmittal, **include the time spent in performing these services** in your critical care time. Do not report/bill for these services separately:

•*The interpretation of cardiac output measurements (CPT 93561, 93562)*
•*Chest x-rays, professional component (CPT 71010, 71015, 71020)*
•*Blood draw for specimen (CPT 36415)*
•*Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data-CPT 99090)*
•*Gastric intubation (CPT 43752, 91105)*
•*Pulse oximetry (CPT 94760, 94761, 94762)*
•*Temporary transcutaneous pacing (CPT 92953)*
•*Ventilator management (CPT 94002 – 94004, 94660, 94662)*
•*Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)*

Resources

MS Manual Pub 100-04 Medicare Claims processing Transmittal 1548