Erica Remer, MD, Inc | CDI ICD-10

PUTTING MENTATION BACK INTO DOCUMENTATION

It is Critical to get Critical Care right!

Erica E. Remer, MD, CCDS
President and Founder
Erica Remer, MD, Inc.
icd10md@outlook.com

Putting MENTATION back into Documentation

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1

Objectives

- After attending this session, participants will be able to:
  - Identify the three criteria mandated to bill Critical Care Time (CCT)
  - Choose appropriate clinical scenarios for Critical Care billing
  - Guide providers to document to support Critical Care billing
  - Compute CCT according to CMS and CPT guidelines

2

2

Lots of opportunity for improvement

Part B Services	Improper Payment Rate	Percentage of Service Type Improper Payments by Type of Error				
		No Documentation	Insufficient Documentation	Medical Necessity	Incorrect Coding	Other
Hospital visit – Critical Care	20.1%	3.4%	27.7%	0.0%	67.9%	1%

- From 2020 Medicare FFS Supplemental Improper Payment Date Report

3

3

Let's start with some examples

4

4

Case 1 - HPI

59-year-old female history of hysterectomy and more recently postop week 6 from pelvic floor surgery presents with vaginal bleeding

Patient has done well since her surgery. Today she was evaluated in the clinic by her surgeon and had some mild degree of vaginal bleeding. This was well-controlled in the office with silver nitrate.

A few hours after this appointment she developed rather sudden onset of more substantial bleeding. She feels with standing the bleeding intensifies. She is not having dizziness lightheadedness shortness of breath. She does not take blood thinners or antiplatelet medication. She is otherwise been in her normal state of health

5

5

Case 1 – P.E., labs

- T 36.6, HR 82, RR 18, BP 140/60, O2 99%
- Constitutional:
  - General: She is not in acute distress.
  - Appearance: Normal appearance. She is not ill-appearing or toxic-appearing.
  - Skin: skin is warm and not jaundiced. [no mention of being pale]
  - Apparently GU exam deferred to OB/GYN [no mention of witnessing blood]
- CBC: Hb 13.4, plt 315. Coags not performed.

6

6

Case 1 - MDM

- MDM:
  - 59-year-old female here with vaginal bleeding in the surgical bed from recent surgery
  - On arrival stable normal hemodynamics. No symptoms concerning for consequential blood loss. OB/GYN was consulted who did quite promptly evaluated the patient. Reportedly the anterior wall of the vaginal vault had some areas of nonpulsatile bleeding. Surgicel was placed the patient was observed for 2 hours and had ongoing although quite mild bleeding.

CCT or not?

Compare with CCT attestation

- (MDM:
  - 59-year-old female here with vaginal bleeding in the surgical bed from recent surgery
  - On arrival stable normal hemodynamics. No symptoms concerning for consequential blood loss. OB/GYN was consulted who did quite promptly evaluated the patient. Reportedly the anterior wall of the vaginal vault had some areas of nonpulsatile bleeding. Surgicel was placed the patient was observed for 2 hours and had ongoing although quite mild bleeding.)

- **Critical care attestation – 50 minutes claimed:**
  - **Patient came in with brisk sudden onset bleeding with recent surgery. Large-bore IV was placed type and screen obtained. Immediate consultation with surgical staff from obstetrics and gynecology. Bleeding did require aggressive source control with Surgicel packing in the vaginal vault. The patient required extended period of observation in the emergency department monitoring for recurrent bleeding with careful attention to hemodynamics and patient's overall clinical status.**

9

Case 2 - history

65 yo, angioectasias of small bowel with previous cautery and acute blood loss anemia, CAD with CABG feeling lightheaded X 2 days with nausea and vomiting initially. Lethargic, fatigued, and near-syncopal upon standing. No melena, hematochezia or hematemesis. No chest or abdominal pain; mild shortness of breath.

10

Case 2 - PE

- T 36.1, HR 53, RR 16, BP 82/35, O2 98%
- General: Not in acute distress, not ill-appearing, toxic-appearing or diaphoretic.
- HEENT: Mucous membranes moist. No scleral icterus.
- Card: Regular rhythm. Bradycardia.
- Rectal exam: no gross blood, stool brown. Occult blood sent.
- Skin: Cap refill < 2 seconds. Skin is pale.
- Neuro: Normal

11

Case 2 - labs

- WBC: 6.0, Hb 7.2, Hct 24.0, plt 460
- BUN 36, Cr 1.53
- NT-proBNP 1,706
- Lactate 1.3
- Troponin < 0.012
- Coags normal

12

Case 2 – ED Course

- Ultrasound does not demonstrate collapse of the inferior vena cava → does not suggest hypovolemic
- Bradycardia – "Could also be just overmedicated with nitrates and beta blockers"
- Anemic and will require blood transfusion

ED COURSE and CLINICAL IMPRESSION

ED Course

2101	Ultrasound was applied to assess for volume status there was no collapse of the inferior vena cava with deep inspiratior
2101	Patient is not having any infectious symptoms. He has just been feeling lightheaded and dizzy near syncopal and hypotensive. He has not had any melena or hematochezia. No hematemesis. He has had nausea but has not had emesis since this past weekend.
2108	EKG shows sinus bradycardia with prolonged QT interval of QTc of 465 ms, QT interval 481 ms, sinus bradycardia is rate is 53, PR interval 189 ms, QRS duration 83 ms, no ST changes noted.
2113	Differential is broad and includes cardiogenic shock, myocardial infarction, sepsis, GI bleed. Could also be just overmedicated with nitrates and beta-blockers.
2210	Chest x-ray shows no confluent infiltrate improvement of the interstitial edema that he had on previous chest x-ray.
2240	Patient is anemic will require blood transfusion. Discussed with Dr. who agrees to admit the patient. Will keep him n.p.o. tonight in case he needs to have an EGD done. He is currently on Plavix and aspirin. He had the ectasias that were cauterized previously but he is not having any melanotic stools nor is he having hematemesis.

13

13

Case 2 - CCT

- Critical Care time: 40 minutes
- Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Cardiac failure and circulatory failure

- Diagnosis:
  - Anemia, unspecified type
  - Hypotension, unspecified hypotension type

14

14

CCT or not?

15

Case 2 – from inpatient H&P

- Fecal occult blood test is positive
- Dx: Acute GI bleeding with hemorrhagic shock, acute blood loss anemia requiring transfusions, History of upper GI bleed due to angioectasia, acute kidney injury

- Don’t you like these diagnoses better?!

16

Case 5

- HPI: 37-year-old male here with GI symptoms
  Over the past few days patient's had nausea vomiting diarrhea. He has diffuse abdominal pain without any reported migration to the right side. No reported fever or chills no reported blood or mucus in the stool. No known recent antibiotic use
- P.E.: Constitutional: HR 120 BP 140/94
  - General: He is not in acute distress.
  - Appearance: Normal appearance. He is not ill-appearing or toxic-appearing.
  - Mouth/Throat:
  - Mouth: Mucous membranes are moist.
- BUN/Cr: 17/0.74, AST 46, ALT 81. WBC 12.4

17

17

Case 5

- MDM: On arrival patient has mild tachycardia fluid responsive. He is afebrile overall nontoxic. He does not describe symptoms of consequential colitis specifically no hematochezia or mucus in the stool. No recent antibiotic use to raise concern for C. difficile. He received 2 L of IV fluids Toradol IV pain control Zofran with good effect. He had stable normal hemodynamics through his ED course and on discharge.

- **CCT attestation: Patient with severe diarrhea hypovolemia evidenced by tachycardia on arrival. He was aggressively resuscitated with fluids required numerous IV medications including antiemetics and 2 separate analgesic meds. He had evidence of end organ injury with transaminitis elevated white blood cell count.**

18

18

Balancing act for the clinician

Don't want patient to look too sick for medicolegal considerations

Want patient to look sick enough for billing considerations

https://www.wannapik.com/vectors/22922?search%5Bquery%5D=step

What diagnoses require critical care?

It's not just the diagnosis/chief complaint

- Not every diabetic with high blood sugar or dizziness is critical care time
- Not every wheezing COPDer or asthmatic is critical care time
- Not every dehydrated GI patient is CCT
- A trauma alert without mechanism or evidence of injury is not de facto CCT
- Not every patient presenting with tachycardia requires CCT (41 yo with ST)
- Anaphylaxis, yes; any old allergic reaction, not necessarily.

- Many patients have affected body systems which could have *potential* deterioration - that does not necessarily equate to CCT
- Is there a high probability of imminent deterioration or impending development of life or limb threat?

21

21

22

Site

- Critical care can be provided in any venue
- The examples provided are from the ED, but CCT can occur in ICU, on the floor, in the office
- Any provider can bill critical care time

- However, just being in the ICU does NOT critical care make

23

23

Provider

- Critical care can be provided concurrently by practitioners in different specialties, if the service they provide meets the definition of critical care, is not duplicative of other services, and cross the time threshold:
  - E.g., an intensivist and a nephrologist can both provide critical care if they are managing different critically ill organ systems
  - E.g., the emergency physician may manage the airway, and the trauma team may be doing the general trauma care concurrently

24

24

3 things mandated to bill Critical Care Time

1. Critical illness or injury
2. Critical care services including high complexity decision making
3. Duration of 30 minutes or more

Must fulfill all three

25

25

Critical illness or injury

- Acute impairment (or acute on chronic)
- Affecting one or more vital organ systems
  - E.g., CNS, circulatory, shock, renal, hepatic, metabolic, respiratory
- High probability of imminent deterioration or development of life or limb threat

- Can express this in narrative thought process or formal differential diagnosis
- They shouldn't leave this to reader's imagination

26

26

High complexity medical decision making

- Good to be explicit because IF documentation doesn't meet CCT, want to, at very least, hit highest level of service
- Number and complexity of problems
  - 1 or more chronic illnesses with **severe** exacerbation, progression or side effects of treatment
  - 1 acute or chronic illness or injury that poses a threat to life or bodily function

27

27

Critical care services

- Provider must be in the ED/on the floor, immediately available, their attention directed to that patient (i.e., they can't be examining Patient B in another room and count that time towards Patient A's CCT)
- Does not have to be at bedside
- Does not have to be continuous time
- Trainee time is not included
- In split/shared scenario (e.g., with NP or PA), the provider who spends the majority of time can count the time. Time is additive.
- Unless they are solely taking care of that patient for the entire duration, they have to mentally start and stop the "critical care clock time" over the course of the shift

28

28

Critical care services/time

- Just being in the department isn't the critical care. Nursing time doesn't count towards CCT. It is the active management by the provider of the patient and their care, for example:
  - getting history and doing physical exam
  - reevaluations
  - activity at bedside like applying pressure to bleeding site, pushing a medication or squeezing a blood bag
  - reviewing labs, other test results, and old records
  - ordering medications and treatments
  - discussions with surrogates if patient is unable to participate
  - discussions with consultants, ancillary staff (e.g., respiratory therapist, social work), outside providers, admitting staff
  - documentation in medical record
- The provider doesn't need to document each thing they did, though

29

29

Critical care bundled services

The following services are included in "critical care clock time" when performed during the critical period by the same physician(s) providing critical care and should not be reported (or billed) separately:

- the interpretation of cardiac output measurements (CPT 93598)
- pulse oximetry (CPT 94760, 94761, 94762)
- chest x-rays, professional component (CPT 71045, 71046)
- blood gases, and collection and interpretation of physiologic data (e.g., ECGs, blood pressures, hematologic data)
- gastric intubation (CPT 43752, 43753)
- transcutaneous pacing (CPT 92953)
- ventilator management (CPT 94002-94004, 94660, 94662)
- and vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)

Any services performed that are not listed above may be reported separately

30

30

Time

- Time spent directly and singularly focused on critically ill/injured patient
- It is NOT start and end times of interaction with patient
- Just because a patient is on a drip in the department (e.g., insulin drip, diltiazem, etc.) does not equate minute to minute as critical care time (e.g., 840 min CCT claimed for 14 hours on an insulin drip)
- Times shouldn't add up to more than the time in their shift or in a day!
- Recommend documenting contribution of NPP and EP to determine who is the billing provider. It looks weird if the NPP takes care of the sick patient for the first 3 hours and then the EP who takes over bills CCT.

31

31

CCT

Critical care provider statement:
Critical care time (minutes): **180**
Critical care start time: **6/24/2024 7:05 PM**
Critical care end time: **6/25/2024 7:35 AM**

- Was the critical care time almost 12 hours or 180 minutes?
- 180 minutes is 3 hours. That's a long time to devote to a single patient.

- How about this one? Go by the claimed time? The start/stop time?

Critical care provider statement:
Critical care time (minutes): **80**
Critical care start time: **6/3/2024 8:30 PM**
Critical care end time: **6/3/2024 9:30 PM**

32

32

Payer dependent

- CPT is more lenient. Must cross the threshold.
- CMS set the bar higher. Must meet the maximum number.

CPT			CMS	
Less than 30 minutes	Appropriate E/M codes		Less than 30 minutes	Appropriate E/M codes
30–74 minutes	99291 X 1		30–103 minutes	99291 X 1
75–104 minutes	99291 X 1, 99292 X1		104 minutes	99291 X 1, 99292 X1
105–134 minutes	99291 X 1, 99292 X2		134 minutes	99291 X 1, 99292 X2
135–164 minutes	99291 X 1, 99292 X 3		164 minutes	99291 X 1, 99292 X 3
165 minutes and longer	99291 and 99292 as appropriate (see illustrated examples above)		165 minutes and longer	99291 and 99292 as appropriate (see illustrated examples above)

33

Peculiarities of counting CCT

- Patient presents critically ill, and provider starts evaluation and treatment at 11:39 pm. At 12:35 am, provider puts orders in and goes into next room to see another patient. At 1:40 am, provider checks labs, reviews and interprets radiographs, contacts consultant and admitting physician, and documents over the next 45 minutes.
- The provider can bill:
  a. 99291 on Day 1 and 99291 on Day 2
  b. 99291 + 99292 on Day 1
  c. 99285 on Day 1, 99291 on Day 2
  d. Depends on whether the patient is being billed under CMS or CPT

34

34

Crossing midnight

- If time is *continuous*, counts as a single unit from date of onset. Cross midnight and cross 30 minutes cumulatively, → CCT
- When provider stops taking care of the patient, the time clock stops
- When provider starts with patient again (on that next day), the clock starts anew. If cross 30 minutes, new 99291

35

35

Two providers

- Provider A sees critically ill patient at end of their shift for 35 minutes.
- Provider B picks up patient and provides 50 minutes of CCT during their shift.

- How is this billed?
  a. Provider A bills 99291 and Provider B bills 99291
  b. Provider A gets all 85 minutes because they started the critical care
  c. Provider B bills 99291 because they have the majority of the time
  d. Provider B bills for 85 minutes (CMS: 99291; CPT: 99291 + 99292)

36

36

CCT is additive

- Even if they don't meet the threshold, if they provide critical care to a critically ill patient, they should document your time
- If a colleague in the same group/specialty provides CCT to the patient in the same encounter, the time is additive.
- Time is usually attributed to last provider in calendar day.
- Only one 99291/group/day. Can have multiple units of 99292, and it is calculated at the end of the day or the end of the critical care.
- Sometimes facilities try to sort out RVUs independent of billing.

37

Split/shared

- NPP starts taking care of a critically ill patient and spends 30 minutes doing the initial H&P and inputting orders. The NPP and the physician go into the patient's room together, discuss the patient and the plan for 8 minutes. The physician calls their nephrology colleague to arrange dialysis, reviews results, and documents. It takes them 25 minutes to accomplish this.
- Which is correct?
  a. The physician can claim the CCT because they are ultimately responsible for the MDM
  b. The NPP takes 99291 because they crossed the 30-min threshold, and the MD can bill 99285
  c. The NPP takes 99291 because they crossed the 30-min threshold and the MD doesn't bill
  d. The MD can claim 33 minutes of time and they would bill 99291 under themself for the total 63 min

38

Conjoint time

- Can’t double dip
- One or the other provider can accept credit for the time
- Attestation is key

Documentation can make or break it

Internal inconsistency

- "Hemodynamic stability and MAPs in the 70 range" →

  Dx: Septic shock

- General: She is not in acute distress.
  Pulmonary: Effort: Respiratory distress present.

Not sick or sick???

41

41

This is consistent

Physical Exam
Vitals and nursing note reviewed.
Constitutional:
General: She is in acute distress.
Appearance: She is well-developed. She is ill-appearing.
HENT:
Head: Normocephalic and atraumatic.
Eyes:
Pupils: Pupils are equal, round, and reactive to light.
Neck:
Trachea: No tracheal deviation.
Cardiovascular:
Rate and Rhythm: Tachycardia present.
Pulmonary:
Effort: Respiratory distress present.
Breath sounds: No wheezing.

Clinical Impressions as of 02/24/23 1605
Pneumonia of right lung due to infectious organism, unspecified part of lung
Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction present (HCC)

42

42

Critical care?

- Pneumonia of both lungs due to infectious organism, unspecified part of lung

43

Diagnoses can be friend or foe

ED Course
Mon Dec 18, 2023

1242 Patient has bilateral alveolar opacities-pneumonia. She is influenza positive.

1306 Patient continues to be tachypneic and her oxygen saturation is 88% on 6 L. Will switch the oxygen to Vapotherm. Her influenza is positive. Chest x-ray shows bilateral infiltrate. This was conveyed to the patient. Awaiting procalcitonin, D-dimer, BNP

1509 CT scan of the chest was interpreted by me. The patient does have bilateral pneumonia.

1540 IMPRESSION:
1. Suboptimal timing bolus for pulmonary embolism. No large central pulmonary embolism identified.
2. Patchy bilateral pulmonary opacities and left lower lobe consolidation concerning for atypical pneumonitis.
3. Hepatic steatosis.
4. Probably reactive axillary, mediastinal and hilar lymph nodes.

ED Course User Index

Clinical Impressions
Pneumonia of both lungs due to infectious organism, unspecified part of lung

- Bilateral pneumonia due to Influenza A with acute hypoxic respiratory failure
- (Was this viral sepsis?)
- Try to impress upon clinicians that strong diagnoses support medical necessity of CCT

44

"Urosepsis"

- HPI: Patient is an 82-year-old male with a history of BPH, diabetes mellitus type 2, hyperlipidemia, hypertension, hypothyroidism, lumbar stenosis with neurogenic claudication, diabetic nephropathy, who on Monday of this week was seen in the emergency room for acute urinary retention and an indwelling Foley catheter was placed. He has been having difficulties with it since then stating that the urine does not spontaneously drain out but he has to push in order to get urine out and it burns in his penis when he does this. He is also now is noticing blood tannish to gross blood in the catheter. No flank pain. No abdominal pain. No nausea or vomiting. No fevers or chills. Patient is not on any anticoagulants.
- PE: T 36.2, HR 116, RR 16, BP 130/87. Normal appearance. No abdominal tenderness. Neuro normal.

45

"Urosepsis"

- Urine with packed RBCs, WBC 11-20, bact 1+.
- WBC, 17.8, Lactate 2.4
- Fluid bolus and antibiotics, HR 95 and BP 130/81 1 hour later.

46

“Urosepsis”

- Urine with packed RBCs, WBC 11-20, bact 1+.
- WBC, 17.8, Lactate 2.4
- Fluid bolus and antibiotics, HR 95 and BP 130/81 1 hour later.

- **Patient triggered sepsis protocol and critical care time was spent reevaluating the patient ordering test assessing response to treatment and reviewing lab results independently reviewing chest x-ray and monitoring patient's response to treatments.** 35 min CCT claimed.

- Patient admitted for urosepsis.

47

47

Poster child for why “triggering sepsis protocol” ≠ sepsis

48

48

Sepsis

- Septic patients are SICK
- Sepsis-adjacent phrasing: Tripping sepsis protocol, having positive sepsis markers, meeting sepsis criteria, receiving sepsis management, urosepsis
- If they are definitively making the diagnosis, they should make it:

  Sepsis due to [infection] with acute sepsis-related organ dysfunction as evidenced by [organ dysfunction]
- If they think the patient has sepsis but are not sure:
  - Can use uncertain diagnosis terminology: possible, probable, likely, rule-out sepsis
- List sepsis first on their list of impressions. It is the reason why they are most concerned. Make sure it appears on the list!
- If there is no organ dysfunction, reconsider diagnosis.

49

49

Sepsis

- Don’t link organ dysfunction to something else, then it doesn’t count for sepsis
  - E.g., hypotension due to atrial fibrillation with a rapid ventricular response
  - E.g., AKI due to dehydration from vomiting

50

50

Shock vs. hypotension

- Which do THEY think it is?
- The code is selected according to the provider's documentation (not the absolute level of BP or HR)
- They shouldn't leave this to the imagination of the reader
- They shouldn't exaggerate or mislead

51

51

CDI for clinical validity

- **Electrolyte derangement identified with hypokalemia which raises some concern of renal dysfunction despite normal GFR her creatinine has risen approximately 25% which is approaching acute kidney injury level.**

- This patient had a creatinine of 0.74.

52

52

Reasonable CCT? Reasonable time?

- Presents to the emergency room with history of shortness of breath. He states that he has been going on for about a week. Has inhalers which haven't helped much. Comes to the ED for further evaluation. Feels that he has significant swelling of the lower extremity, has been having increased shortness of breath. No history of any chest pain. No history of any palpitations.
- General: He is not in acute distress.
- Appearance: He is well-developed. He is not diaphoretic.
- Pulmonary:
- Effort: Pulmonary effort is normal.
- Breath sounds: Examination of the right-upper field reveals decreased breath sounds. Examination of the left-upper field reveals decreased breath sounds. Decreased breath sounds present. No rales.
- [No extremity exam for edema]

53

53

Reasonable CCT? Reasonable time?

- Received 20 mg Lasix, oxygen for 1 hours, discharged in 4 hours.
- 90 min CCT claimed.

54

54

Case 3

- 34 yo with history of T1DM presents for evaluation of dizziness. States in recent days has had left flank pain some nausea without vomiting and felt dizzy. BS usually 120-180 range. Hasn't been able to eat much last few days. No fever or chills.
- Vitals: T 36.3, HR 90, RR 16, BP 138/102, O2 100%
- P.E. – see next slide

55

55

P.E.

Physical Exam
Vitals and nursing note reviewed.
Constitutional:
General: She is not in acute distress.
Appearance: Normal appearance. She is not ill-appearing or toxic-appearing.
HENT:
Head: Normocephalic and atraumatic.
Nose: Nose normal.
Mouth/Throat:
Mouth: Mucous membranes are moist.
Eyes:
Extraocular Movements: Extraocular movements intact.
Conjunctiva/sclera: Conjunctivae normal.
Pupils: Pupils are equal, round, and reactive to light.
Cardiovascular:
Rate and Rhythm: Normal rate.
Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: No stridor.
Musculoskeletal:
General: No deformity.
Cervical back: Normal range of motion. No rigidity.
Skin:
General: Skin is warm.
Coloration: Skin is not jaundiced.
Neurological:
General: No focal deficit present.
Mental Status: She is alert and oriented to person, place, and time. Mental status is at baseline.
Gait: Gait normal.
Psychiatric:
Mood and Affect: Mood normal.
Behavior: Behavior normal.
Thought Content: Thought content normal.
Judgment: Judgment normal.

- No acute distress.
- Not ill or toxic appearing
- Normal pulmonary
- Normal neuro
- Normal exam

56

56

Labs

Labs Reviewed

COMPREHENSIVE METABOLIC PANEL

Abnormal

Result	Value
Total Protein	8.2
Albumin, Serum	4.2
Total Bilirubin	<0.7
AST	21
Alkaline Phosphatase	80
ALT (SGPT)	14
Sodium	141
Potassium	3.6
Chloride	107
CO2	29
BUN	12
Creatinine	0.64
Glucose	112 (*)
Calcium, Total,S	9.3
Anion Gap	5
Fasting?	No

BLOOD GAS, VENOUS - Abnormal

pH, Ven	7.36
pCO2, Ven	54
HCO3, Venous	30.5 (*)
Base Excess/Deficit	3.7 (*)

BETA-HYDROXYBUTRATE 2.0

- Sodium 141 (WNL)
- CO2 29 (WNL)
- Creatinine 0.64 (WNL)
- Glucose 112 (ULN 100)
- No anion gap
- pH 7.36 (WNL)
- Beta hydroxybutyrate is elevated

57

57

MDM

34-year-old female here with nausea and lightheadedness.

Arrival patient is afebrile nontoxic mild hypertension otherwise normal hemodynamics. DKA labs obtained. Her sugar is 118 on arrival negative for ketones negative for acidosis. She received a liter of IV fluids and Toradol with improvement in her left flank discomfort and overall wellbeing. She received a second liter of fluids and began taking fluids orally.

Had a blood glucose of 58 during her ED course. We discussed that she will need to monitor her glucose regularly today and moving forward to ensure that her control is appropriate. Repeat glucose had improved although still in the low end. Patient was advised to be observed further to ensure that the glucose stabilized in the normal range. She declined and left with instructions to return immediately if she had worsening symptoms.

Differential diagnosis: Hypovolemia, dehydration, DKA, electrolyte derangement, UTI, pyelonephritis, gastritis, pancreatitis.

Clinical impression: Lightheadedness, dizziness.

58

58

From CCT attestation

- Glucose 58 required immediate glucose administration. Dehydration with fluid responsive tachycardia – 2 liters IVF bolus with effect
- CCT: 60 minutes

59

59

CCT or not?

60

60

Decision tree for provider

- Acute impairment of one or more vital signs? Of one or more organ systems?
- High probability of imminent deterioration or development of life or limb threat?
- Are critical services being provided? High complexity MDM?
- Guesstimate total critical care time. Carve out separately billable procedures. Give a discrete number.
- If split/shared, figure out who has majority of time and document it.
- 99291 for first 30 – 74 or 103 min; 99292 for additional time (just crack threshold or entire 30 min; depends on payer)

61

61

Decision tree for you

- Is the patient really or potentially really sick?
  - Acute impairment of one or more vital signs? Of one or more organ systems?
  - High probability of imminent deterioration or development of life or limb threat?
- What was the disposition (if ED)? Discharged patients can receive critical care, but it should be highly scrutinized. If they were admitted to the ICU or died, more likely.
- Are critical services being provided? High complexity MDM? If there are 2 providers from different services billing CCT, are the conditions and services not duplicative?

62

62

Decision tree for you

- Did the provider give you solid diagnoses? If not, is there room for CDI?
- Did the time cross the threshold of 30 min? No range or >.
- If they cross midnight, count continuous time for first day. If there is a break, start clock on next day.
- If there are multiple providers from same service line/group who each report CCT, add up and then assign according to your protocol/practice.
- If split/shared, figure out who has majority of time. Encourage good attestation/documentation.
- What is the payer? Medicare (CMS) vs. other payer (CPT). Use matrix.
- 99291 for first 30 – 74 or 103 min; 99292 for additional time (just crack threshold or entire 30 min; depends on payer)

63

63

References

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- https://www.cms.gov/files/document/r11288CP.pdf
- Byron J, Is It Really Critical Care? American Institute of Healthcare Compliance blog, June 1, 2021. https://aihc-assn.org/is-it-really-critical-care/ Beware: came out before changes in CCT. There are a few inaccuracies.

64

64

Questions?

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PUTTING MENTATION BACK INTO DOCUMENTATION

It is Critical to get Critical Care right!

Erica E. Remer, MD, CCDS
President and Founder
Erica Remer, MD, Inc.
icd10md@outlook.com

Putting MENTATION back into Documentation

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