We Are…

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Experts of Acute Unscheduled Care

Resuscitation

High acuity presentations

Consideration of most dangerous diagnoses

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HALO Events and Procedures

- Aortic dissection
- Acute Coronary Syndrome
- Severe electrolyte derangements
- Pulmonary embolism
- Angioedema
- Diabetic ketoacidosis

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Resuscitating Your Chart: A Crash Course on Critical Care Documentation

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Critical Care CPT Definition

> *"A critical illness or injury 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.."*
> *(AMA/CPT)*

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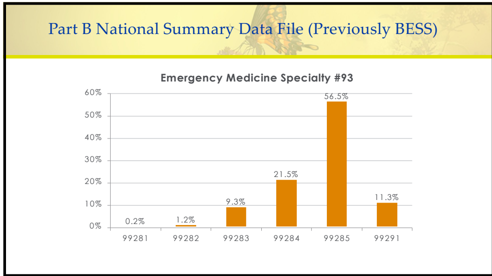
Part B National Summary Data File (Previously BESS)



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Critical Care: The Math

CPT Code	RVUs	Approx. Payment
99283	2.13	$85
99284	3.58	$140
99285	5.21	$205
99291 (critical care)	6.31	$255

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Critical Care: Supporting Criteria

- **Potential** for life threatening deterioration
- **Hard finding:** diagnostic or exam
- **Intervention** to prevent deterioration
- 30 minutes of physician care outside of separately billable procedures

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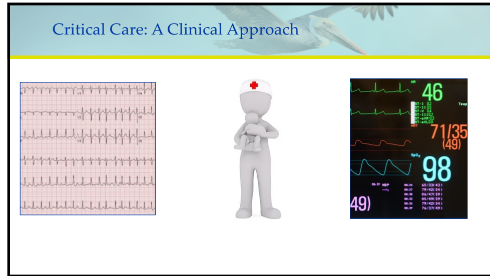

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Hard Findings – Vital Signs

- Hypotension/hypertension
- Hypoxia
- Tachycardia
- Tachypnea
- Fever

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Interventions – Medications and Procedures

Medications

- Anticoagulation: lovenox, heparin, integrilin
- Allergy/asthma: epi, magnesium
- Antiarrhythmic: adenosine, diltiazem, amiodarone
- Antidotes: naloxone, IV dextrose, bicarb, charcoal
- Blood products: pRBC, platelets, Kcentra
- Pressors: epi, norepi, dopa

Procedures

- BIPAP/CPAP/HFNC
- Intubation
- Bag valve mask
- Central line
- Cardioversion
- Chest tube
- CPR*

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Potential Critical Care Diagnoses

- Severe sepsis/septic shock
- Acute coronary syndromes
- Atrial fibrillation with RVR and arrythmia
- COPD/asthma exacerbation
- Acute pulmonary edema
- Hyperkalemia with EKG changes
- DKA
- Intracranial hemorrhage
- GI bleeding
- Pulmonary embolism
- Substance withdrawal

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Critical Care- Disposition

- Transfer to a higher level of care
- ICU
- Telemetry
- Discharge after significant improvement

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Inclusion: Time Spent

- At the bedside
- Full attention to the patient
- Ordering/reviewing diagnostic tests
- Treatment discussions with family and EMS after patient arrival
- Treatment discussions with consultants or appropriate source
- At least 30 minutes
- **Cumulative, not consecutive**

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Time Not Counted: Separately Reportable Procedures

- Central line
- Laceration repair
- Thoracostomy
- Intubation
- CPR
- Time after patient expires

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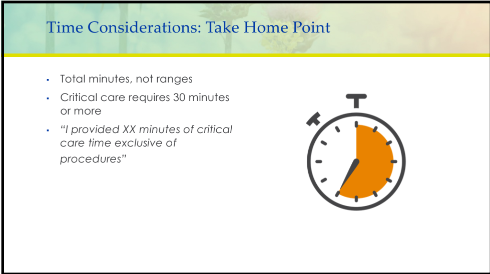

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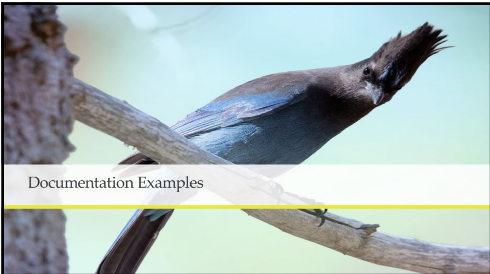

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Hyperkalemia

Progress Notes, Medical Decision Making and Critical Care *.procdoc*

38 year old male, known ESRD on (M/W/F), coming in today after missing his last dialysis session. +mild SOB. VS 190/80, 90, 12, 95% on RA. +crackles b/l lung bases. Cxr interpreted by me, mild edema no infiltrate. EKG interpreted by me, peaked Twaves in the precordial leads, which is new when compared to previous EKG on 10/24/2022. Labs - K is 7.9, nl bicarb.

Spoke with Dr. Kidney, nephrology, who will help facilitate dialysis in the AM. Will keep in hospital. For the acute on chronic hyperK with EKG changes, patient was given insulin/glu, albuterol, and calcium. Discussed with admitting team.

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Atrial Fibrillation With RVR

Progress Notes, Medical Decision Making and Critical Care *.procdoc*

55 yo F, history of atrial fibrillation on AC, hypertension, hyperlipidemia, presents to the ED with 4 hours of palpitations. No associated SOB or chest pain. Onset was sudden, non-exertional, not associated with diaphoresis. Upon arrival, initial heart was 140 with a systolic BP around 120. Electrolytes were reviewed, no significant abnormalities, a CTA was performed to evaluate for pulmonary embolism and read as negative by radiology.

EKG is consistent with atrial fibrillation with RVR. A diltiazem bolus and infusion has been ordered. Most recent heart rate is 120. Discussed with hospitalist who will continue treatment plan during hospitalization.

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Allergy/Anaphylaxis

Progress Notes, Medical Decision Making and Critical Care *.procdoc*

Patient arrived with an acute allergic reaction - diffuse urticaria, expiratory wheeze, and initial blood pressure 100/60. Was brought back to a treatment room, given fluids, benadryl, steroids, and nebs, and epinephrine.

Reassessment at 1330: lungs still with expiratory wheeze, no retractions. Urticaria appears less pronounced. BP 110/85

Reassessment at 1400: mild scattered wheeze. Second liter running. Urticaria resolved.

Reassessment at 1445: Pt reports feeling better. Clear lungs.

1530: Blood pressure has consistently been >130 systolic. Plan to monitor for 2 more hours, if no rebound, will dc.

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Acute Psychosis

ED Course as of

0944 Pt with persistent agitation. HR 145. Verbal de-escalation attempted. Tangential, non-linear thought process. Worsening acute psychosis and a potential danger to himself and others. Concern about metabolic derangements possible acidosis. Ordering haldol, benadryl, and ativan. [ET]

0948 Pt more calm, resting in bed. HR has improved to 110. Will continue to reasess. [ET]

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Pulmonary Edema

Progress Notes, Medical Decision Making and Critical Care *.procdoc*

Eval most consistent with acute cardiogenic pulmonary edema. Initially RR 32, labored breathing, course BS. BP significantly elevated 220/130, Sa02 90% on 15L NRB.

Was started on BiPAP , high dose NTG gtt, and furosemide.

CXR, interpreted by me, with diffuse pulmonary edema and cephalization. External record review - admitted with similar presentation to this hospital 6/15/2022, inpatient notes show BNP range 1500-2000.

Reassessed at 1230, RR is much improved, breathing is less labored, no longer diaphoretic. Will continue with BiPAP and continuous monitoring. Repeat BP 200/100. Anticipate admission to IMC/ICU.

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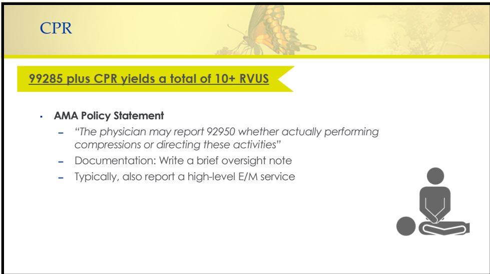

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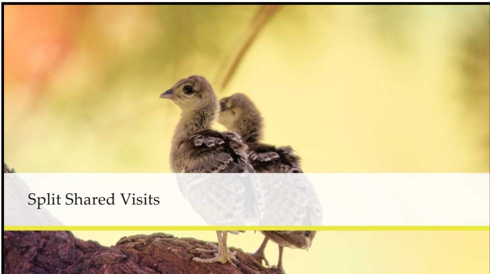

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Split Shared Visit for 2022 and 2023

- Cumulative time may be reported
- Clinician with more than half (substantive time) will get the credit

Critical Care Shared Visit Physician Attestation Example:
"I personally saw the patient. PA Green and I provided critical care for a total of 40 minutes. I provided a substantive portion of the care and the majority of the critical care time."

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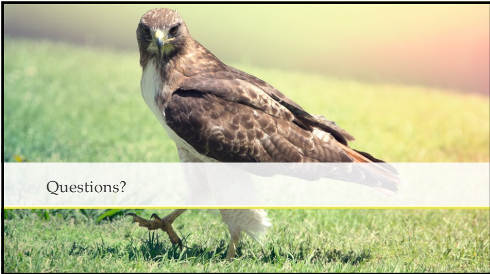

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Key Take Home Points

- Critical care is often under reported
- Consider the potential for deterioration, hard findings, and interventions
- Time
- No major changes in split shared visits

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