Critical Thinking:
Tips to Improve Critical Care Defensibility

This month's documentation tips come straight from the front lines. Over the past several months, we've witnessed increasing payer scrutiny of critical care. The purpose of this message is to relay a few pointers gleaned from those reviews to help your critical care charts survive payer review.

As a refresher, the CPT manual currently defines a critical illness or injury as an illness or injury that 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. Consistent with coding industry practice, we assign critical care codes only when specifically directed by the provider and therefore accept the provider's clinical judgment. However, in light of the attention given to these codes by Medicare, Medicaid and various commercial payers, we wanted to furnish some brief, yet practical, documentation tips to consider when assigning critical care.

1. Don't Shoot Yourself in the Foot. Including statements in your chart that are generally inconsistent with critically ill or injured patients gives auditors an easy opportunity to question the validity of your assignment. Here are some examples of what we're talking about, each of which was pulled from a real critical care chart:

    - Notation in the constitutional of "no acute distress"
    - Finding of "normal" vital signs
    - Documentation that the patient is in "stable condition" when presenting
    - Observation of only "moderate" symptoms.

    Sometimes, these phrases appear because an EMR macro inadvertently inserted them into the record. If that's the case, review and revise your EMR template. On the other hand, if the patient is truly in "no acute distress" or has "moderate symptoms", consider whether critical care is really the right code choice.

2. Discharged Patients. When an auditor looks at a critical care chart, one of the first things they check is whether the patient was admitted. In their minds, a discharge from the ER is big red flag. They will question whether the patient was really suffering from a life-threatening condition if just hours later, they are sent home. That's not to say that every critical care patient must be admitted. It's just that if you have one of those unique instances where the critically ill patient is discharged from the ER, be sure and explain your reasoning thoroughly because you will be facing an uphill battle in a review setting.

3. Keep Painting. Similar to the previous point, make it a habit to explain why you feel your case warrants critical care. Auditors often see critical care claims where the chart bears no evidence to support the code, beyond a short notation of time spent. In these cases, the auditor is going to deny the claim under the theory that if the care is not documented, it didn't happen. You've heard us say "paint the picture" of your care before, and that's what we're talking about here. One way to get into the habit of painting your picture is to free type and complete the phrase, "CC was rendered in this case because [___________]" in the chart of every critical care case you see. While it might be redundant in a few instances, the chances are good that this notation will eliminate any doubts about your work in the face of an audit.