CHEST Online Supplement

Physician Reimbursement for Critical Care Services Integrating Palliative Care for Patients Who Are Critically Ill

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e-Appendix 1. Sample Documentation

Sample A. Critical Care Specialist Clarifies Goals of Care and Establishes Treatment Plan with Surrogate for Critically Ill, Incapacitated Patient in Emergency Department.

The patient is a 92 year old woman with end stage dementia admitted from a nursing home with recurrent pneumonia and a large, painful, sacral decubitus ulcer. For several months, PO intake has been poor and this is her third hospitalization for infection. A directive not to attempt resuscitation came with her from the nursing home. I was called emergently to the ED to provide critical care input including evaluation of hypotension and clarification of goals of care. My examination revealed an obtunded, cachetic, tachypneic and tachycardic woman with shock (BP 80/60), bronchial breath sounds c/w pneumonia over the left lower lung field posteriorly, and a 4 cm necrotic ulcer on her sacrum. I met with the patient's daughter, who is the legally-designated surrogate, at the ED bedside to discuss goals of care and appropriate treatment options. In light of the patient's condition and prognosis and in accordance with her prior stated wishes, we agreed that the patient would be treated with antibiotics and IV fluids, but that we would not initiate mechanical ventilation or vasopressor medications. In event of arrest, no attempt will be made to resuscitate – DNR directive issued per the surrogate. Comfort will be maximized as we proceed with other care. Because the patient appears to have pain and dyspnea, I have initially ordered morphine 2 mg IV push now and every 30 minutes as needed.

Total critical care time: 120 minutes
CPT Codes 99291 and 99292 x 2
ICD-9: Acute respiratory failure 518.81, Pneumonia 482.9, Shortness of breath 786.09; Pain 780.96; Debility 799.3; Dementia 294.10

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Sample B. Discussion and Management of Withdrawal of Mechanical Ventilation by Pulmonary Attending Physician in the ICU.

The patient is a 53 year old woman with stage IV non small cell lung cancer that is metastatic to the brain and liver. After a week in the ICU, she remains critically ill, ventilator-dependent, comatose from anoxic encephalopathy after a cardiac arrest on ICU Day 3. After seeing the patient on ICU rounds this morning, I had a 45-minute meeting with her two sons (joined by social worker, ICU medical resident, and critical care nurse) this afternoon in the ICU to discuss her illness and goals of care. We reviewed the option of a time-limited trial of ongoing mechanical ventilation versus palliative extubation. The sons reported that the patient had previously stated in clear terms that she would not want continuation of "heroic measures" if she were cognitively impaired in circumstances such as these. We agreed to withdraw the ventilator, while pursuing aggressive control of symptom distress. I signed a DNR order. Upon extubation, the patient became tachypneic and agitated, appearing uncomfortable. We started a fentanyl infusion at 50 mcg/hour and Haloperidol 1 mg IV every six hours for these symptoms. If agitation persists, I have ordered lorazepam, 2 mg IV q 1 hour prn.

Total critical care time: 75 minutes
CPT Codes 99291, 99292
ICD-9: Acute and chronic respiratory failure 518.84, Shortness of breath 786.09; Coma 780.01; Anxiety 300.00; Lung cancer 162.9.

Sample C. Oncologist Discusses Resuscitation Status with Surrogate and Manages Patient's Pain and Delirium

The patient is a 45 year old man with esophageal cancer. He was transferred two days ago to a regular medical unit after a 2-week ICU stay for treatment of intraabdominal sepsis. I was called today urgently to evaluate him for clinical deterioration. He is hemodynamically unstable - BP=70/40 mm Hg, HR=165, with hypoactive delirium and a distended abdomen; he is moaning and grimaces to abdominal palpation. I met with his wife and bedside nurse to discuss treatment options including control of symptoms and delirium, and to discuss the patient's preferences regarding CPR. The patient lacks capacity for medical decisions. His wife referred to an advance directive specifying that resuscitation should not be attempted if the patient arrests; on this basis, I entered a DNR order. In addition, the wife also confirms that – under these circumstances – the patient would not want to return to the ICU for advanced life support including mechanical ventilation or vasopressors. Will start a morphine infusion at 2 mg/hour for abdominal pain, with further titration as necessary for comfort. Will also give Haloperidol, starting with 1 mg IV push, to address delirium.

Total critical care time: 60 minutes
CPT Code 99291
ICD-9: Septic shock 785.52, Abdominal pain 789.05, Alteration of mental status 780.97, Esophageal cancer 150.9.