2023 Reimbursement Strategies

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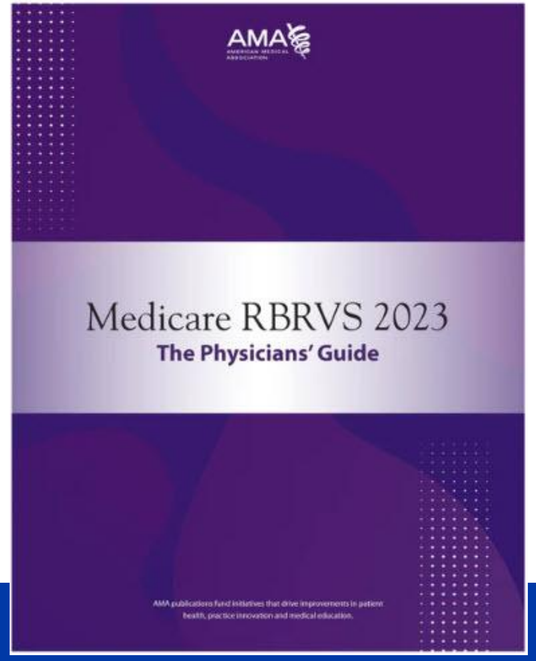
RBRVS Equation

Work RVUs
Practice Expense RVUs
+Liability Insurance RVUs
Total RVUs for a given code



RVU_{Total} X Conversion Factor (CF) = Medicare Payment

RVU Potential Problem: The Fight for 99284

"The RUC recommended a wRVU decease to 2.60 for 99284, a commenter submitted a public comment stating that (relativity between the ED visits and Office visits visits should be maintained), and submitted a specific recommendation for CPT codes 99283-99285 that was higher than the RUC-recommended values."

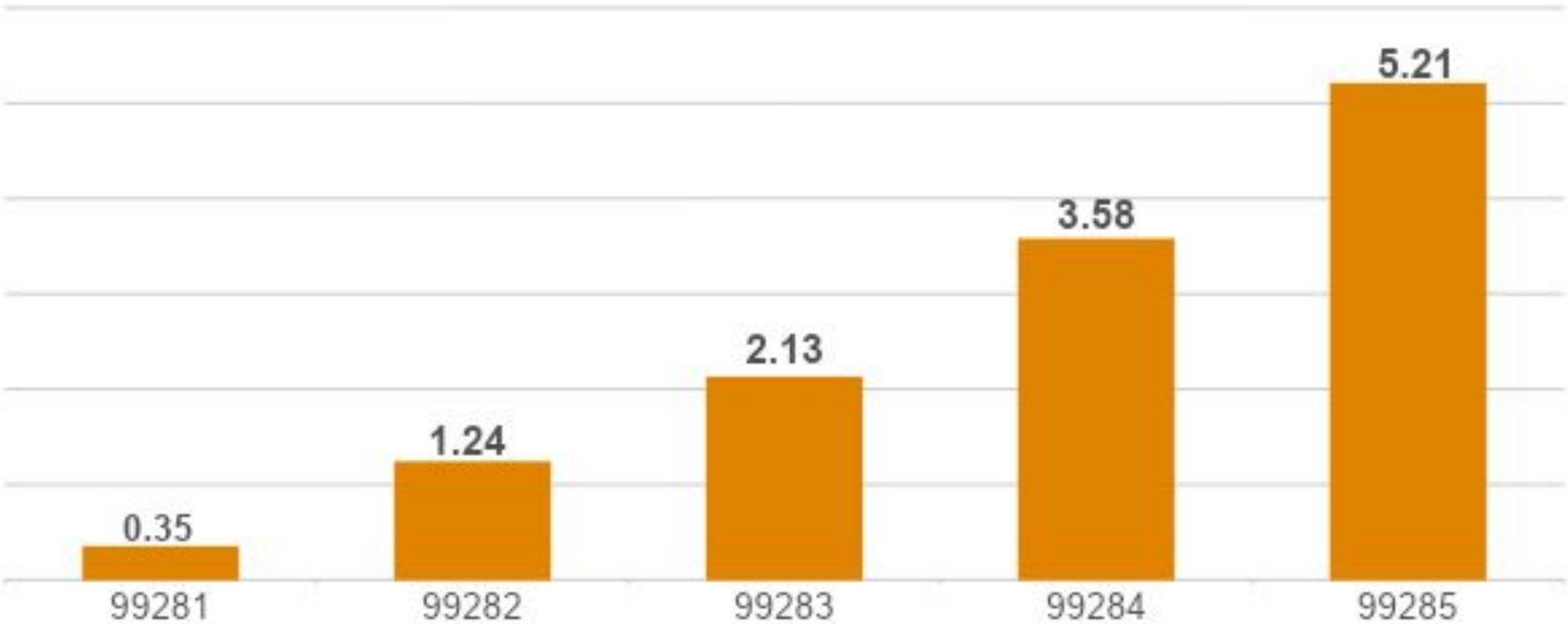
"We proposed and now finalized the values recommended by this commenter in this final policy and increased the work RVU from 2.60 to 2.74 for CPT code 99284."

2023 CMS Physician Final Rule page 669/3304

2023 Work RVUs Stabilized

Code	2022 Work RVU	2023 Work RVU
99283	1.60	1.60
99284	2.74	2.74
99285	4.00	4.00

2023 RVU Increases With Each E/M Level



Final 2023 Medicare Payment per RVU

NEWS FROM THE AMA

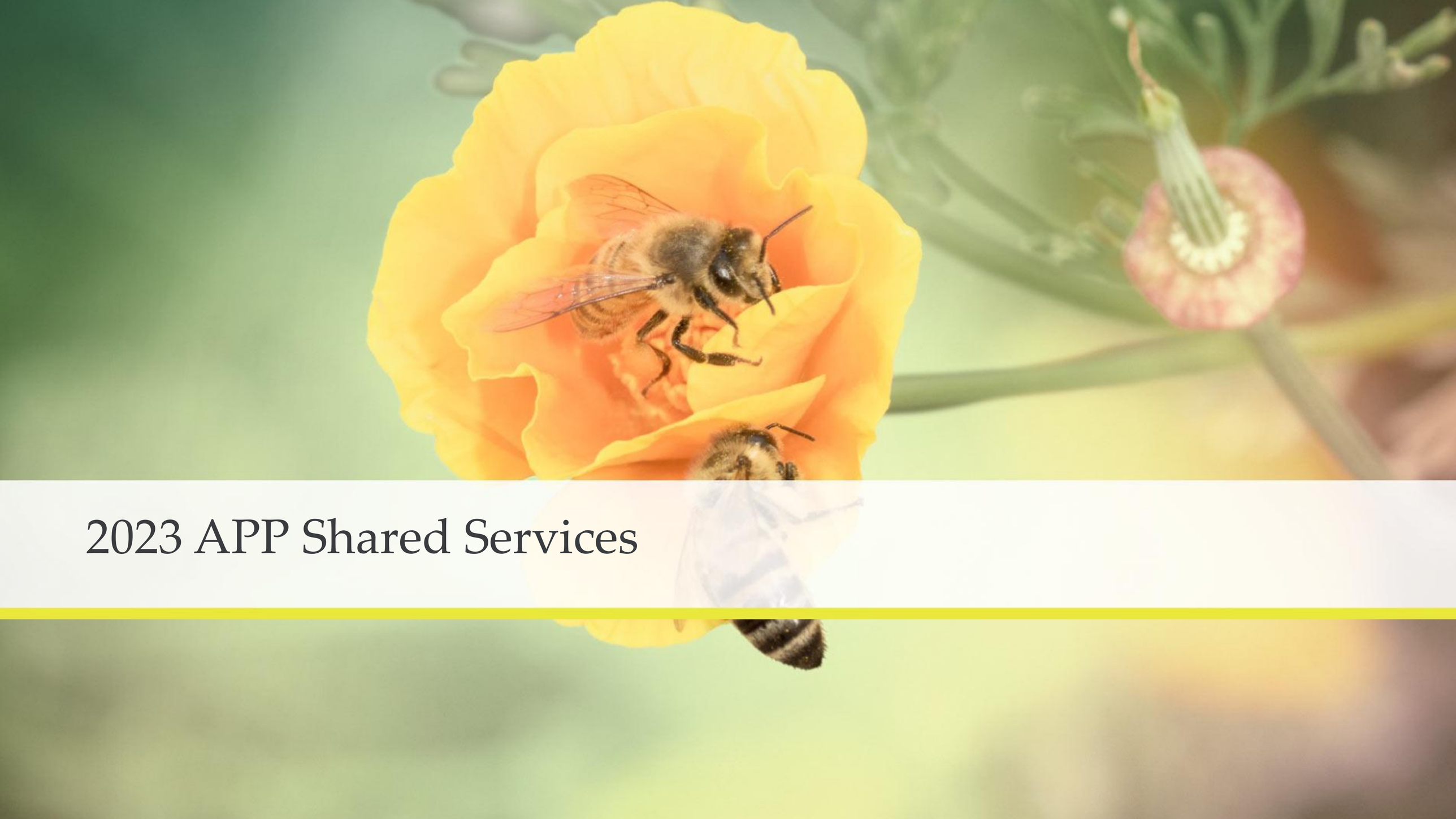
AMERICAN MEDICAL ASSOCIATION

JANUARY 5, 2023 PRESS RELEASE:

"CMS has released updated national Medicare physician payment files that incorporate the changes in the Consolidated Appropriations Act of 2023. Congress reduced the 4.5% cut to Medicare physician payment by increasing the 2023 conversion factor by 2.5%. The updated 2023 Medicare physician payment schedule conversion factor will be **$33.8872**."

Year	Conversion Factor
2018	$35.9996
2019	$36.0391
2020	$36.0896
2021	$34.8931
2022	$34.6062
2023	$33.8872

2023 CMS National Fee Schedule



2023 APP Shared Services

Shared Visit Performance Requirement

- Longstanding CMS policy allows Physician NPI billing if a **"substantive portion"** of an APP shared visit performed
- 2022 Final Rule addressed how to define **"substantive portion"**:
  - more than half of the total time spent performing the shared visit; OR
  - one of the three key components: history, exam, OR MDM

"If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed."

2022 CMS Physician Fee Schedule Final Rule page 425/2414

2023 ED Shared Services Almost A Big Problem

"Having reviewed the public comments and consulted with our medical officers, we do not believe that an alternative process for ED visits is the best approach at this time. As we discussed above, only for 2022, we will allow history, or exam, or MDM, or more than half of the total time, to comprise the substantive portion of any E/M visit (including ED visits) except critical care. Starting in 2023, the finalized listing of qualifying activities will apply to all split E/M visits except critical care, for purposes of determining the substantive portion."

2022 CMS Physician Fee Schedule Final Rule page 434

TABLE 26: Final Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

2023 Shared Services: A Victory!

"As part of our ongoing engagement with interested parties, we are hearing continued concern about the implementation of our phased in approach with regard to defining "substantive portion" only as more than half of the total time of the visit, and continue to receive requests that we also recognize MDM as the substantive portion"

2023 CMS Physician Final Rule page 669/3304

*"After considering the public comments we received, we are finalizing our proposed policy to **delay implementation** of our definition of the substantive portion as more than half the total practitioner time until **January 1, 2024.**"*

2023 CMS Physician Final Rule page 672/3304

Good News: Shared Visits Expanded-Include Critical Care

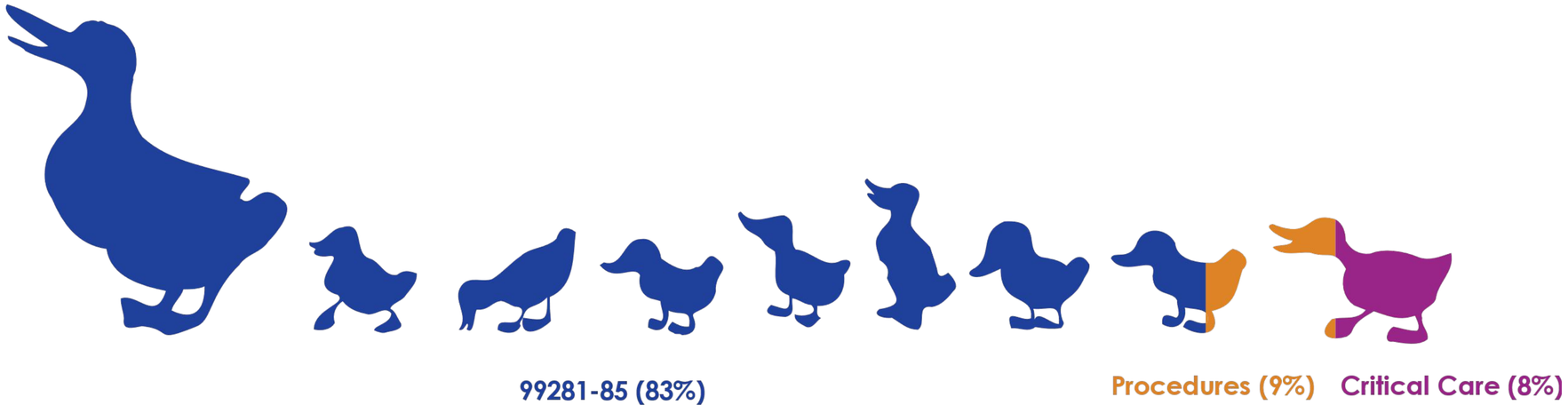
"We also proposed to modify our policy to allow physicians and NPPs to bill for shared visits for both new and established patients, and for ***critical care*** *and certain Skilled Nursing Facility /Nursing Facility (SNF/NF) E/M visits. We proposed these modifications to the current policy and conditions of payment to account for changes that have occurred in medical practice patterns, including the evolving role of NPPs as part of the medical team."*

2022 CMS Physician Fee Schedule Final Rule page 425/2414

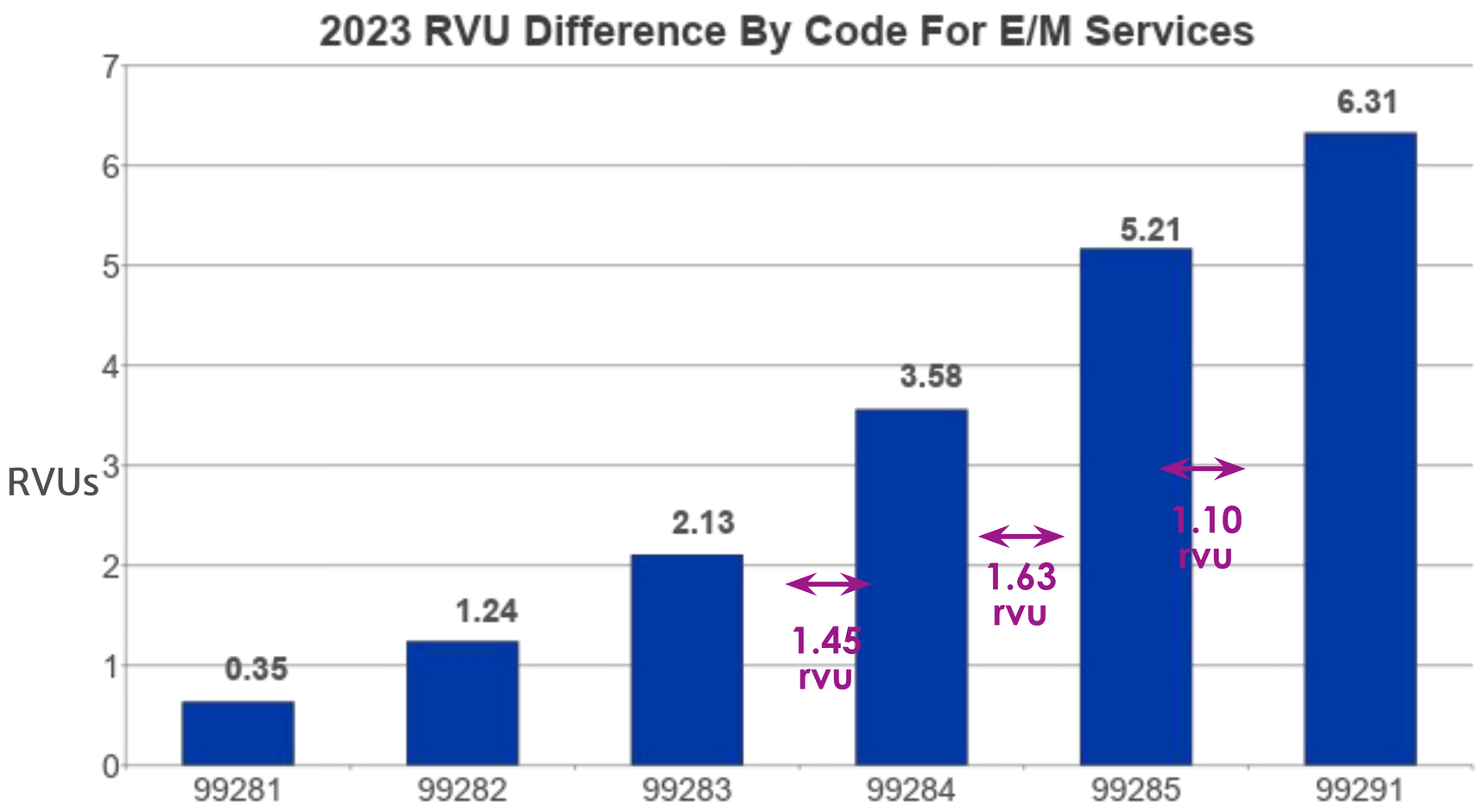
2023 Documentation Guidelines: Protecting Your RVUs

Why Are The New Documentation Guidelines Important?

- 83% of typical ED doc's RVUs from 99281-99285
- 8% from critical care
- 9% from procedures



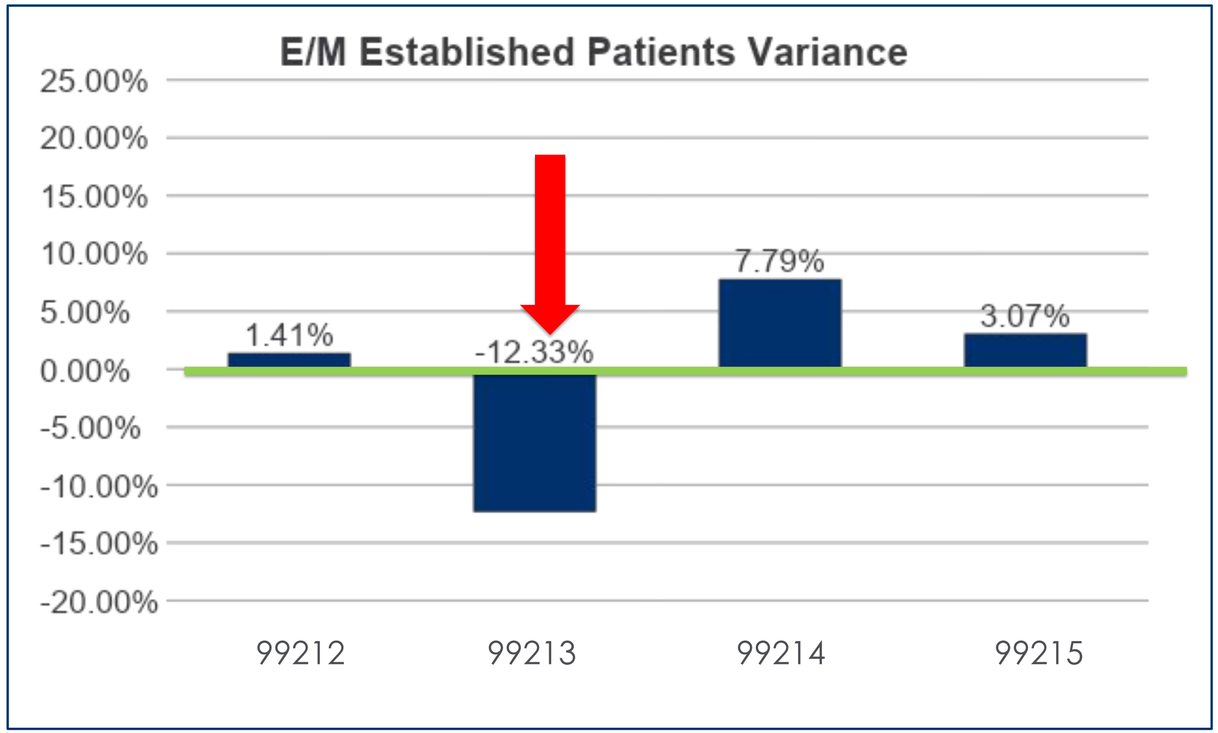
Drill Down On The 2023 RVUs

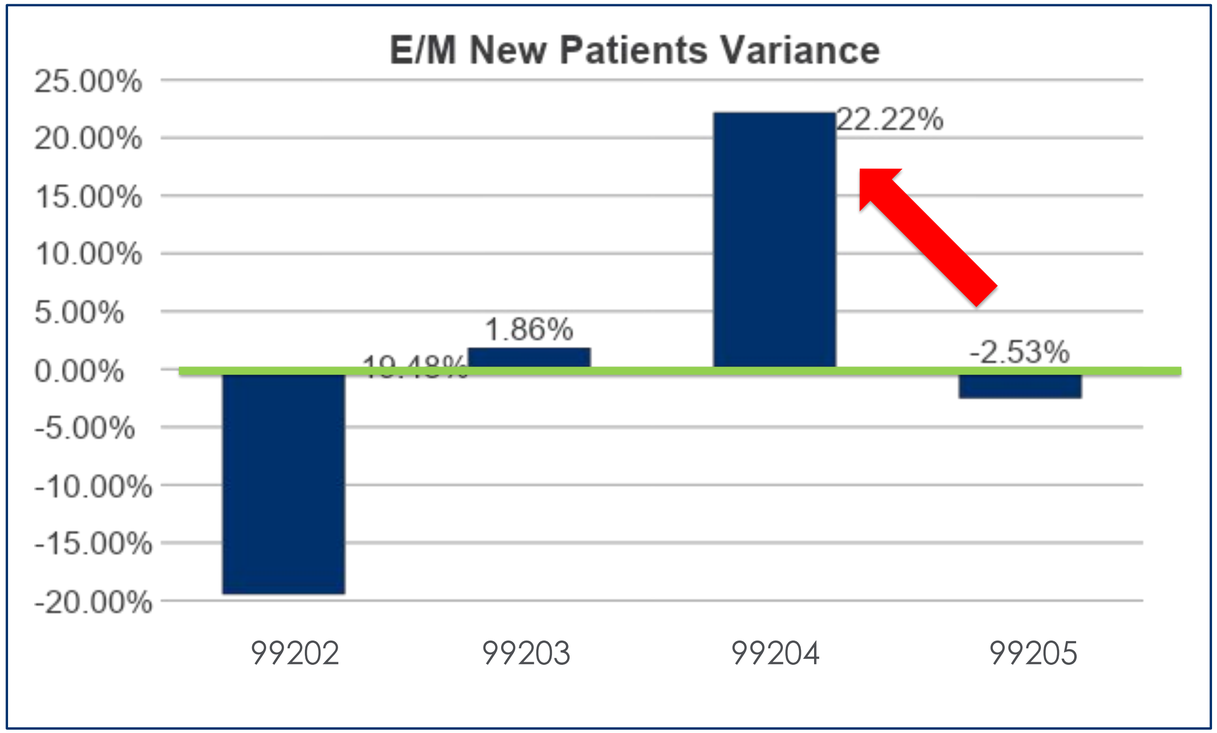


AMA Guidance: Coding Distribution Shift

Early Results of Top Performers

After examining initial results, some trends are starting to emerge. Well-prepared organizations are showing a shift to level four visit utilization based on the new E/M guidelines. Here are initial results from one organization:



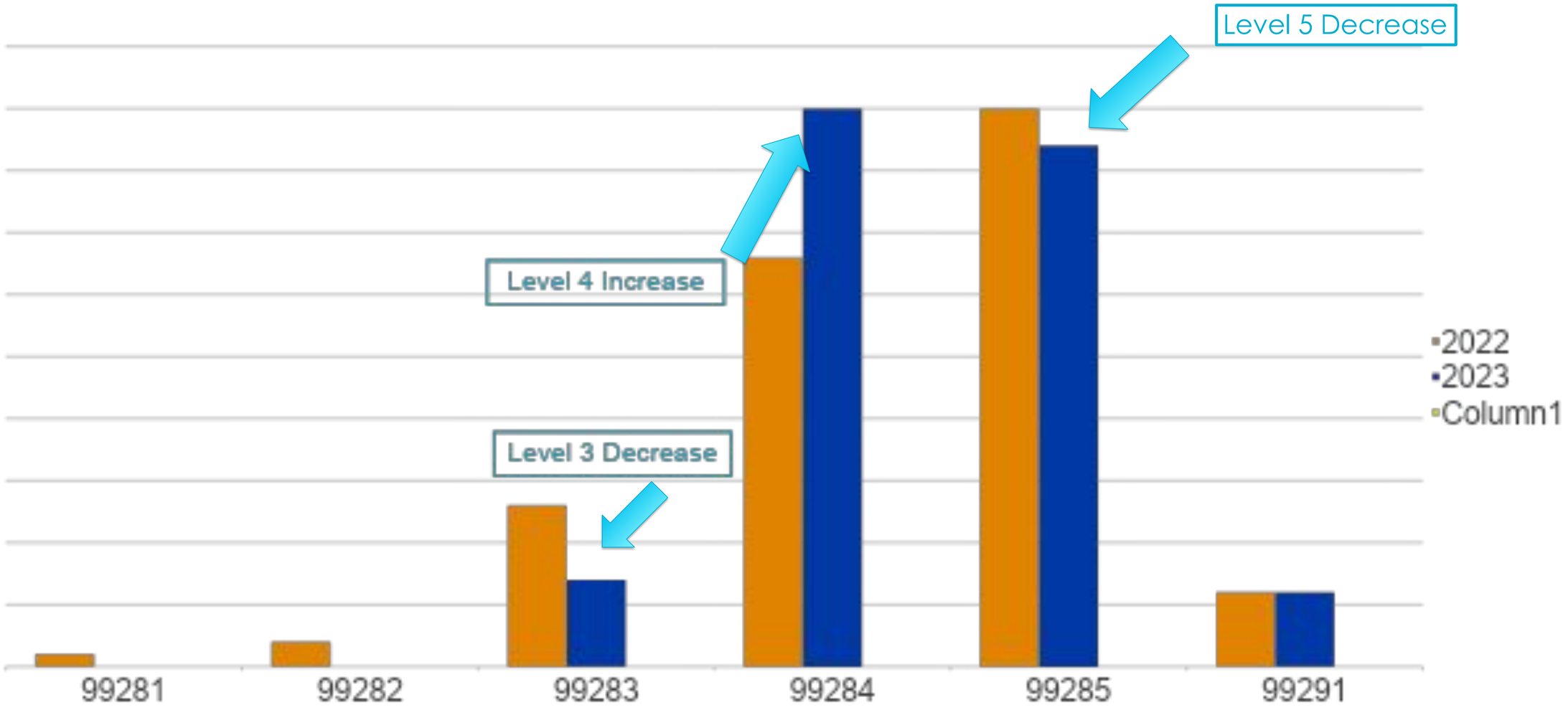


2023 Getting the Coding Right

Case Study: "Effectively Prepared Group"
fully ready for 2023 DG changes

- Resources to digest new policies
- Develops sophisticated expertise
- Updates the EHR
- Preparation: Physician didactics, lectures, newsletters and webinars
- Ongoing education, monitoring, auditing, and chart feedback

2022 vs 2023 E/M Distribution



Consequences of Sub Optimal Preparation

- Case Study: "Somewhat Prepared Group" less ready for the 2023 DGs
  - Coding policies are found to be complex
  - Can't engage resources
  - Resources lack ED expertise
  - Coders lightly updated
  - Level 5s go down significantly
  - Appropriate 3 to 4 transition doesn't take place
  - .3 RVU/patient decrease
    - 60,000 visits X $45/RVU X .3 RVU/patient = $810,000

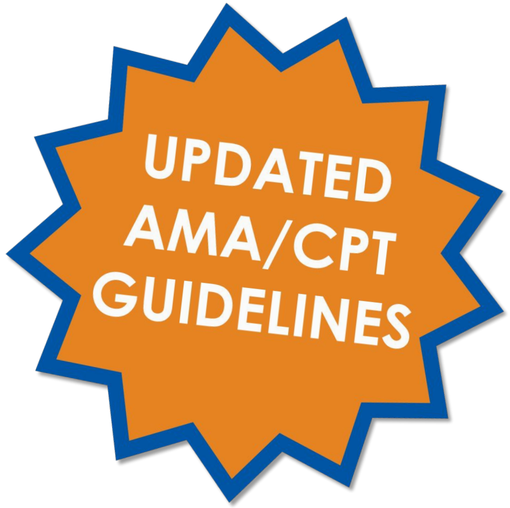
Collective Participation: Benchmarking the Transition

- In the transition to the 2023 Guidelines which of the below is ***true***
  - Level 5s might decrease somewhat TRUE ✓
  - Level 3s will decrease with a shift to level 4 TRUE ✓
  - Level 1s and 2s will be uncommon TRUE ✓
  - Overall the intent of the guidelines was not to decrease ED RVU/patient TRUE ✓

All of the Above Are True

The Basics: 2023 History and Physical Exam Don't Score

- "The nature and extent of the history and/or physical examination is determined by the treating physician."
- "The extent of history and physical examination is NOT an element in selection of codes."
- "The main purpose of documentation is to support care of the patient by current and future health care teams."



2023 CPT E/M Descriptors and Guidelines

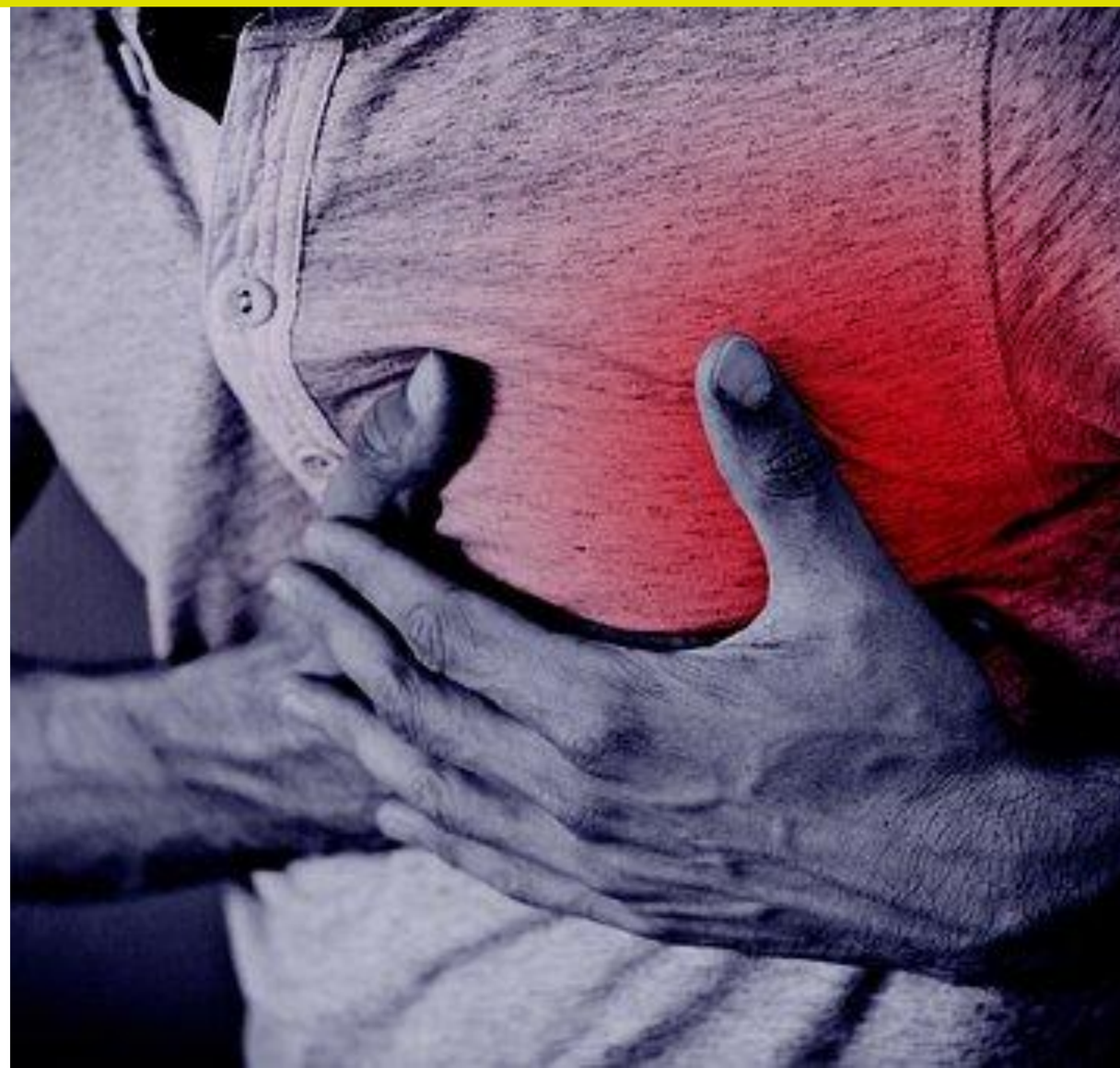
Do I Still Need to Document a History? Think Clinical

History

48 y.o. male presents with left sided chest pain, worse with exertion, associated with diaphoresis.

Episodes last 2-3 minutes and are relieved by rest.

(Clinically Important)



Decreased Documentation Burden: Physical Exam Think Clinical

Physical Exam

Key Area of Note Bloat

Physical Exam
Vitals reviewed.
Constitutional:
General: Patient is not in acute distress.
Appearance: Normal appearance, but is **diaphoretic.**
Comments: **Appears uncomfortable**
HENT:
Head: Normocephalic and atraumatic.
Eyes:
Extraocular Movements: Extraocular movements intact.
Neck:
Vascular: No carotid bruit.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds. No murmur heard.
Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: Normal breath sounds.
Abdominal:
General: Abdomen is flat.
Palpitations: Abdomen is soft.
Tenderness: There is no abdominal tenderness.
Neurological:
General: No focal deficit present.
Mental Status: Patient is alert and oriented to person, place, and time. Mental status is at baseline.
Psychiatric:
Mood and Affect: Mood normal.
Behavior: Behavior normal.

2023 ED 9928X Codes Will Be Based on MDM Alone!

2023 ED: Level Assignment Is All About the MDM

2023 CPT E/M Descriptors and Guidelines July Release

▲99281	**Emergency department visit** for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
▲99282	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
▲99283	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
▲99284	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
▲99285	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

99285 2022

99285 **Emergency department visit** for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

2023 New ED MDM Grid

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		1 Number and Complexity of Problems Addressed	2 Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	3 Risk of Complications and/or Morbidity or Mortality of Patient Management
99281	**N/A**	N/A	N/A	N/A
99282	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99283	**Low**	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

Collective Participation: Which of the Following Is True Regarding 2023 Documentation

Which of the below is ***True?***

1. The coding is based on MDM TRUE ✓
2. Charts will no longer be down coded for PE issues TRUE ✓
3. The Hx and PE still matter- clinical care & medical legal issues TRUE ✓
4. Large macros will likely be used less in the future TRUE ✓

All of the Above Are True

New ED Guidelines: Code Construct Detail

2023 New ED MDM Requirements by Level

Level	2022 MDM	2023 MDM
99281	Straight Forward →	None
99282	Low →	Straight Forward
99283	Moderate →	Low
99284	Moderate	Moderate
99285	High	High

Collective Participation: True or False?

True or False?

1. The 2023 changes decreased the MDM complexity for 99283 from Moderate to Low TRUE ✓

2. As a result of the 2023 changes level 3 will decrease and level 4 will increase TRUE ✓

2023 ED MDM Elements

2023 MDM Elements Determining Code Choice

- Number and **Complexity of Problems** Addressed at the Encounter
- Amount and/or Complexity of **Data** to Be Reviewed and Analyzed
- **Risk** of Complications and/or Morbidity or Mortality of Patient Management

Need to Satisfy Two Out of Three Elements for a Given Level

2023 ED MDM Element: Problems Addressed

Number and Complexity of **Problems** Addressed (COPA)

- Actually less numeric now and more qualitative
  - Acute, uncomplicated illness or injury
  - Acute illness with systemic symptoms
  - Chronic illnesses with severe exacerbation
- Differential Diagnosis, clinical considerations and responses to treatment are supportive

Practical Application:
High COPA Presenting Symptoms & Final Diagnosis

High COPA (99285): 1 acute or chronic illness or injury that poses a threat to life or bodily function.

46 yo male with no past history presents with substernal CP, centrally located with nausea and diaphoresis while at rest.

DDX: ACS, GERD, musculoskeletal.

ED Course: Serial ECGs and troponins negative. Pain relieved by GI cocktail. HEART score 2. DC with outpatient follow up.

Final Dx: GERD.

Practical Application: Moderate COPA Chronic Illness Exacerbation Supports 99284

35 yo M with a history of hypertension presents with a request to have his BP checked. He states he takes his medications irregularly because of difficulty getting to the clinic and affording his medications. Mild ear rushing.
BP 178/92. Denies headache, dizziness, chest pain.

1 chronic illness with exacerbation moderate COPA supports 99284

2023 ED MDM Element: Data

Amount and Complexity of **Data** Reviewed/Analyzed

- Component with the most changes and clarifications
- Dependent on physician documentation frequently
- Key changes:
  - "Old record review" changed to "Review of prior external notes"
  - Independent historian updated to include parents and caregivers
  - Scoring for ordering or reviewing each unique test
  - Independent interpretations

MDM Element Data: Dependent on Physician Documentation

Moderate Medical Decision Making

Category 1: Tests, documents, or independent historian(s)

Any combination of 3 from the following:

- ✓ Review of prior external note(s) from each unique source
- Review of the result(s) of each unique test
- Ordering of each unique test
- ✓ Assessment requiring an independent historian(s)

Category 2: Independent interpretation of tests

- ✓ Independent interpretation of a test performed by another qualified health care professional (not separately reported)

Category 3: Discussion of management or test interpretation

- ✓ External health care professional/appropriate source

What Data That I Review Should Be Documented?

ED Course: 38 y.o. female with multiple sclerosis presents with dysuria and temp 99.5

I have ordered and reviewed the results of a CBC, Chem 12, UA , pregnancy test, Chest X ray and head CT. The Chem 12 is normal with normal electrolytes and LFTS and albumin. (Category 1)

<u>Clinically Relevant:</u>
The WBC is elevated at 14.6. UA shows nitrates, 5-10 WBC, 1+ bacteria (Category 1)

<u>Clinically and Coding Relevant:</u>
CXR **interpreted by me** shows no focal infiltrate (Category 2)

Have **discussed management** with her neurologist who agrees with a dose of Unasyn and will see in the office for recheck tomorrow (Category 3)

Data Category 1: What and How?

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

76 year old presented with altered mental status, fever, and tachycardia. Sepsis order set was initiated, concern for UTI or pneumonia.

ED Course as of 02/16/23 1625

Thu Feb 16, 2023

1600	External records reviewed: pt admitted here, 2/2022 for ACS workup. Echo at that time showed an EF of 55%. Will order a 30 ml/kg bolus. [ET]
1617	CBC noted, 22K, and lactate 2.4. Pt reassessed, BP 105 systolic, HR 110. [ET]

External record review

History of Present Illness

Triage note:
"Intoxication per EMS"

30 year old presents via EMS for evaluation of altered mental status. History is limited due to the acuity of condition.

Independent Historian:

Independent Historian

EMS: arrived at the scene of a young male laying on the sidewalk. Collar placed. Glucose en route 160. Responds to painful stimulus and makes incomprehensible sounds/speech.

Data Category 2: Overview

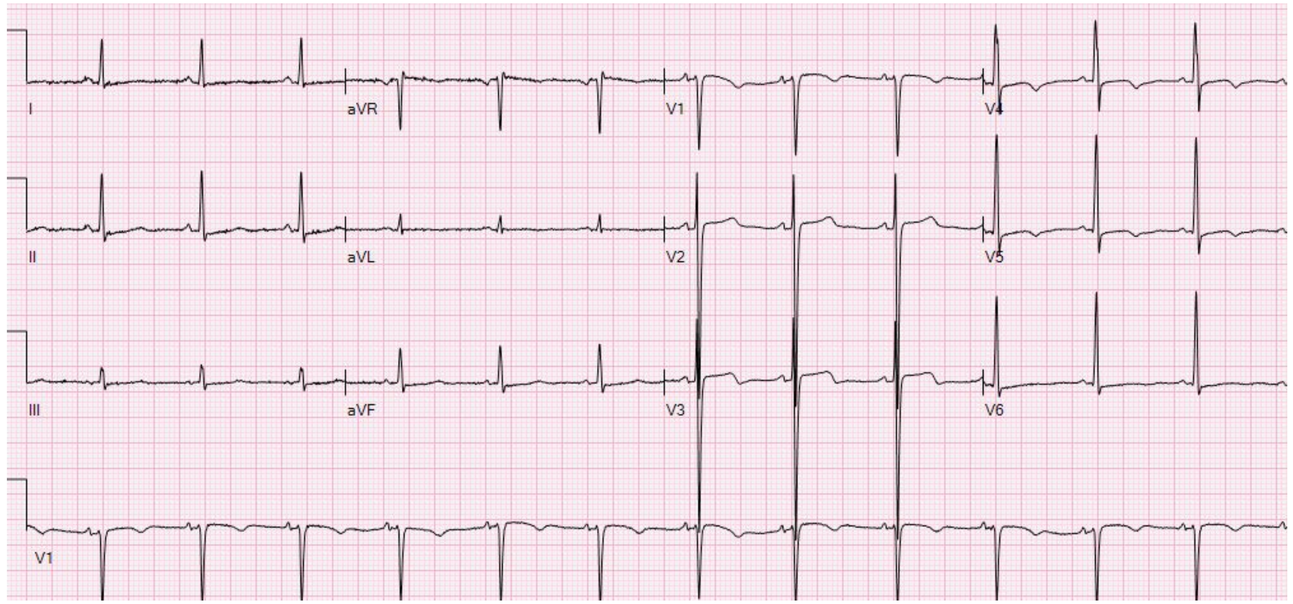
MDM Detail for Category 2:

Independent Interpretation that is clinically meaningful

EKG interpreted by me:

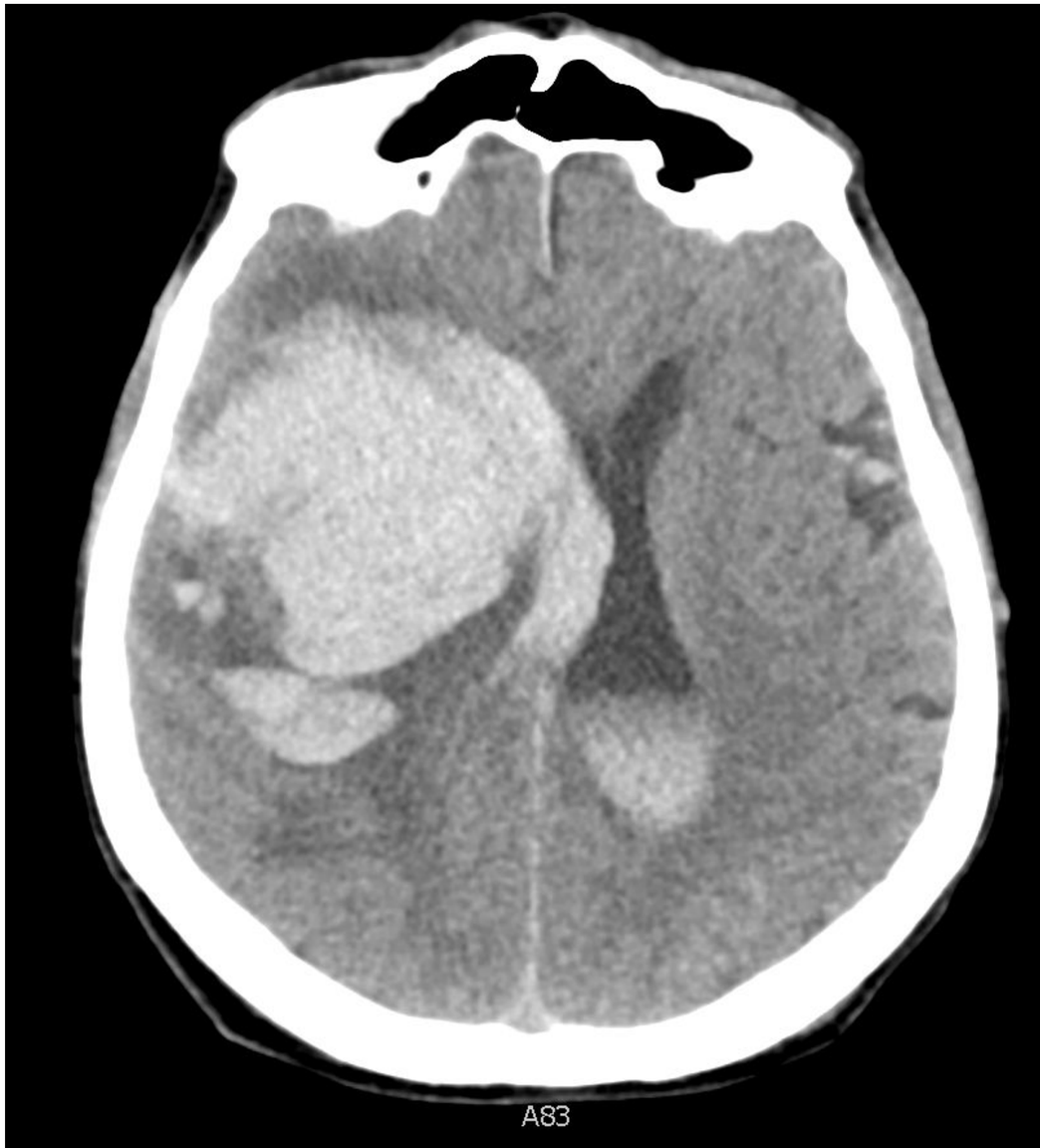
Normal sinus rhythm, T wave inversion consistent with inferolateral ischemia.

Does not need to rise to the level of a billable interpretation to contribute to the MDM. Does not need every last interval.



Data Category 2: Independent Interpretations

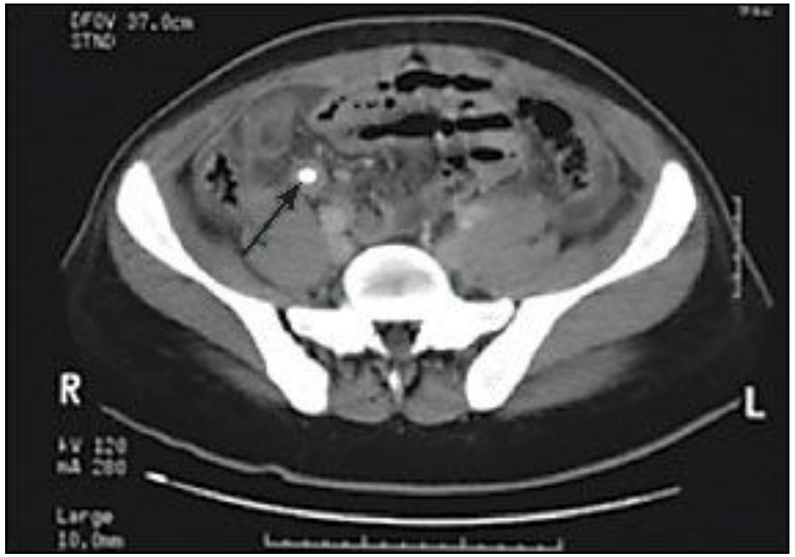
- Not held to the standard of a billable interpretation
  - *"Xray, interpreted by me, no infiltrate or pneumothorax"*
  - *"Per my interpretation of head CT, large ICH, neurosurgery consult initiated."*
  - *"CT abdomen per my independent interpretation, no free air or significant hemoperitoneum."*



Data Category 3: Discussion of Management with External Physician

Patient with continued pain, repeat exam still with focal RLQ tenderness. CT consistent with acute appendicitis. Have discussed with G- Surg who will admit, requests NPO and will take to the OR.

-AB 1/25 1930



Group Collaboration: Data Under Our Control

Which components of data are important to document?

Answer ***Yes*** or ***No*** to the following:

1. Review of external records Yes ✓
2. History from an independent historian Yes ✓
3. Documenting the results of each lab ordered No ✗
4. Independent interpretations Yes ✓
5. Discussion of management with external providers Yes ✓

All But #3 Are Important to Document

2023 MDM Element: Risk

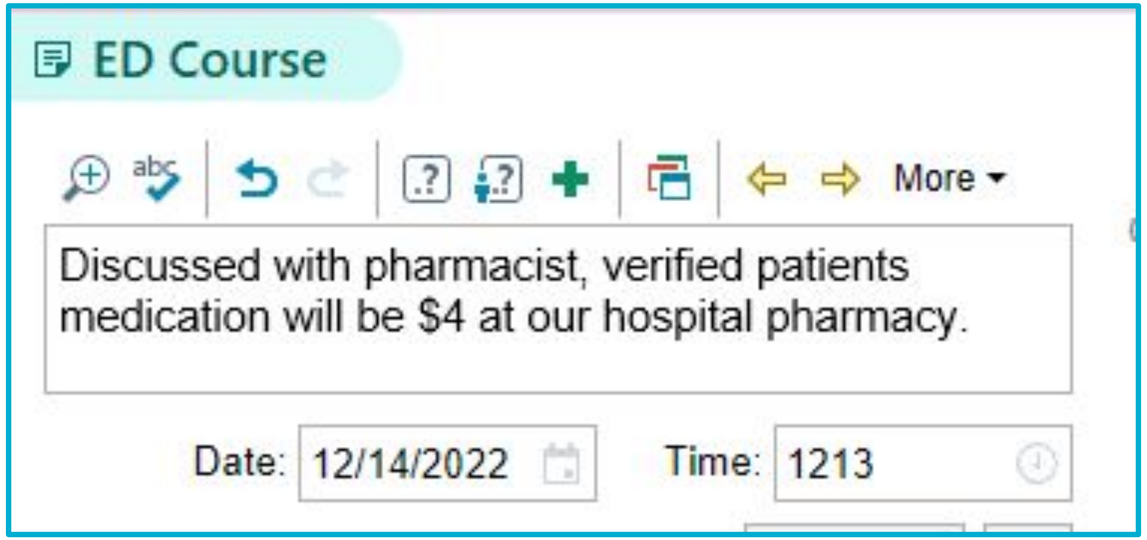
Risk of Complications and Morbidity/Mortality

- Key new changes
  - Moderate Risk:
    - Diagnosis/Tx significantly limited by social determinants of health
    - Prescription drug management appropriately considered
  - High Risk:
    - Parenteral controlled substances continues
    - Medication requiring monitoring
    - Decision regarding hospitalization
    - Decision to de-escalate or escalate care

How Do I Document Social Determinants of Health?

2023 MDM Grid Moderate Risk:
Diagnosis or Treatment significantly impacted by Social Determinants of Health

28 y.o. female recently unemployed and without health insurance presents with dysuria.
UA shows nitrate + and 2+ bacteria.
HCG negative. Plan outpatient antibiotics.
Patient's treatment was significantly impacted by a social determinant of health.



High Risk: De-escalation of Care Transition to Palliative

High Risk- Decision to de-escalate care due to poor prognosis
Supports 99285

ED Course as of 12/24/22 0831

Thu Dec 01, 2022

0830 76 yo F, hx afib on AC, found in bed this morning by husband after not waking up. Was immediately intubated to protect airway, GCS 3T, CT with large ICH, 12 mm shift, uncal herniation. Neurosurgery reviewed CT, described no intervention available and overall poor prognosis. ICU also involved. Both neurosurgery, ICU, and myself met with pts husband, who decided to de-escalate care to palliative measures and not pursue transfer

Overview 2023 ED Medical Decision Making

- Review of external notes (NH, EMS, DC Summary)
- Independent historian (parent, guardian, spouse)
- Independent interpretation of test:
  - EKG, X-ray, CT Scan
- Discussion of management with external provider
- Social determinates of health
- Decision regarding escalation of care/hospitalization

Low Acuity Vignette – Base Case

History

Triage note:
"Sore throat, cough"

15 year old male with 2-3 days of non-productive cough, nasal congestion. No known sick contacts. No change in appetite.

Physical Exam

Constitutional:
Appearance: Normal appearance.
HENT:
Nose: Congestion and rhinorrhea present.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulmonary:
Effort: Pulmonary effort is normal.
Breath sounds: Normal breath sounds. No wheezing.
Lymphadenopathy:
Cervical: No cervical adenopathy.
Skin:
General: Skin is warm and dry.
Neurological:
Mental Status: He is alert.

Clinical Impression and Disposition *.eddispoinstructions .sopend*

1. Acute bronchitis, unspecified organism

ED Disposition: Discharge - 2/15/2023 15:16
Condition at time of disposition: Good

SARS-CoV-2 AND Influenza A,B PCR (Symptomatic)
Final result 02/14 2209

Adenovirus...	Not Detected
Coronavirus...	Not Detected
Coronavirus...	Not Detected
Coronavirus...	Not Detected
Coronavirus...	Not Detected
SARS-CoV-...	Not Detected
Human Met...	Not Detected
Rhinovirus/...	Not Detected
Influenza A...	Not Detected
Influenza B...	Not Detected
Parainflu 1...	Not Detected
Parainflu 2...	Not Detected
Parainflu 3...	Not Detected
Parainflu 4...	Not Detected
RSV RNA A...	Not Detected

Low Acuity Vignette – All the Tools

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

15 year old with 2-3 days of non-productive cough. Also complains of sore throat. No known sick contacts. No change in appetite. His mother adds he had a fever yesterday, 100.5, that resolved with ibuprofen.

Independent Historian (Mother)

COVID and RVP panel negative.

Clinical condition most consistent with viral etiology. Discussed with mother, antibiotics not indicated as likelihood of bacterial infection is low. Discussed need for close outpatient follow up.

Consideration of prescription for antiviral/antibiotics

High Acuity Vignette – All The Tools

Base Case

- 52 y.o. with COPD presents with wheezing and tachypnea. Receives several rounds of nebs. CBC, chem 7, CXR negative. Patient ultimately improves.

- Disposition: Discharged home with PCP follow up.

Using All The Tools

- 52 y.o. with COPD…
- **CXR Independent interpretation:** Chronic changes no infiltrate
- **External note reviewed:** Prior admission baseline O2 sats 92%
- **Consideration regarding hospitalization:** Patient reassessed; still with moderate wheeze, may require admission. Continue nebs and reassess.
- Disposition: DC home and PCP follow up

ACEP Reimbursement FAQS 2023 Documentation Guidelines FAQ

#40

Level of MDM (Based on 2 of 3 Elements of MDM)		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99281	**N/A**	N/A	N/A	N/A
99282	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99283	**Low**	**Low** • **2** or more self-limited or minor problems • **1** stable chronic illness • **1** acute, uncomplicated illness or injury • **1** stable, acute illness • **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source* • review of the result(s) of each unique test* • ordering of each unique test* **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
99284	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment • **2** or more stable chronic illnesses • **1** undiagnosed new problem with uncertain prognosis • **1** acute illness with systemic symptoms • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99285	**High**	**High** • **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	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

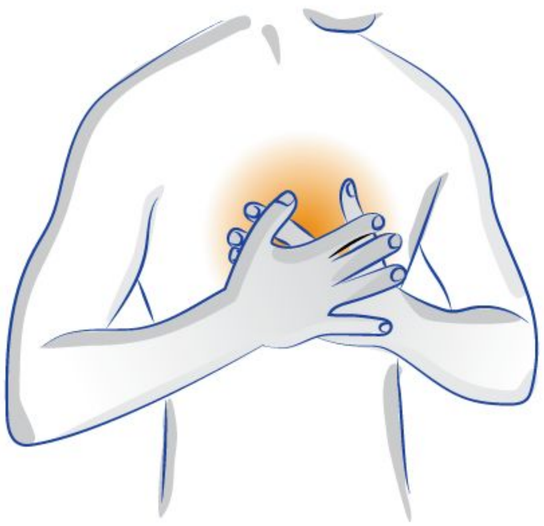
American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Chest Pain and Wheeze Discharged Home

43 year old with a history of hypertension, DM, and smoking presents with vague chest pain, worsened by cough, for one week

Exam: VSS. Well appearing, no murmur, mild expiratory wheeze

Orders: CBC, chemistry, troponin, EKG, BNP, CXR, COVID swab and an albuterol neb



Chest Pain and Wheeze Discharged Home

"Heart score 3 - risk factors, nl EKG, neg troponin, slightly suspicious story. Joint shared decision making regarding potential hospitalization , patient prefers to go home with close outpatient follow up.
PERC negative, BNP normal.
CXR clear, no pneumonia. COVID negative.
On repeat assessment, lungs are clear with complete resolution of wheeze.
Discussed return to ED instructions and outpatient plan."

Need 2 Out of 3

	Component 1 – Problems	Component 2 – Data	Component 3 – Risk
Level 4	Chronic illnesses with exacerbation Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	*(Must meet 1 of 3 categories)* **Category 1: Tests, documents, or independent historian** Three from the following: •Review of prior external notes •Ordering of each unique test •independent historian(s) CBC Chemistry Troponin BNP CXR EKG **Category 2: Independent interpretation of diagnostic test** **Category 3: Discussion of management or test interpretation with external provider**	Prescription drug management Decision regarding minor surgery with risk Diagnosis or treatment significantly limited by social determinants of health
Level 5	Chronic illnesses with severe exacerbation Acute or chronic illness or injury poses a threat to life or bodily function Cough Vague CP Wheeze	(Must meet 2 of 3 categories) **Category 1: Tests, documents, or independent historian** Three from the following: •Review of prior external notes •Ordering of each unique test •independent historian(s) CBC Chemistry Troponin BNP CXR **Category 2: Independent interpretation of Diagnostic test** EKG Interp. **Category 3: Discussion of management or test interpretation with external provider**	Drug therapy requiring intensive monitoring for toxicity Decision regarding hospitalization Decision not to resuscitate or to de-escalate care

Key 2023 MDM Drivers

1. Discussion of management with other providers
   - Hospitalist (admission), consultant (GI, neuro, social work), PMD

2. Independent interpretations
   - EKGs, plain X-rays, CT scans, Ultrasounds

3. Review of external records
   - Inpatient hospital, office records, nursing home

4. History obtained from an independent historian
   - Parent, caregiver, EMS

Key 2023 MDM Drivers

5. Prescription medications or testing appropriately considered
   - Antibiotics, antivirals
   - X Ray, CT Scan

6. Care affected by social determinants of health
   - Homeless, literacy, access to medical care

7. Appropriate consideration of hospitalization or de-escalation
   - Chest pain, COPD, asthma, hyperglycemia

Key 2023 MDM Drivers

8. Chronic illnesses impacting care
   - DM, hypertension, chemotherapy

9. Discussion of test interpretation with external physician/provider
   - D/W radiology re abdominal CT

2023 DGs Strategies for Success

Best Practices

- Digest and distill the new coding policies
- Find an expert in your coding group
- Physician Education now and recurring
- Update your EHR
- Monitor your expected coding distribution carefully
  - Small RVU changes have big monetary impact!
- Ongoing auditing, education, analysis

Conclusions

- Brand new Documentation Guidelines 2023
- Hx/PE only as medically appropriate
- MDM will drive code selection
- Brand new MDM process
- Protect your group: Education and Physician documentation matters!

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