2023 Reimbursement Strategies

Michael Granovsky MD, CPC, FACEP
President, LogixHealth
RBRVS Equation

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

$\text{RVU}_{\text{Total}} \times \text{Conversion Factor (CF)} = \text{Medicare Payment}$
The RUC recommended a wRVU decrease to 2.60 for 99284, a commenter submitted a public comment stating that (relativity between the ED visits and Office 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 Work RVUs Stabilized

<table>
<thead>
<tr>
<th>Code</th>
<th>2022 Work RVU</th>
<th>2023 Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>1.60</td>
<td>1.60</td>
</tr>
<tr>
<td>99284</td>
<td>2.74</td>
<td>2.74</td>
</tr>
<tr>
<td>99285</td>
<td>4.00</td>
<td>4.00</td>
</tr>
</tbody>
</table>
2023 RVU Increases With Each E/M Level
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.”

<table>
<thead>
<tr>
<th>Year</th>
<th>Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$35.9996</td>
</tr>
<tr>
<td>2019</td>
<td>$36.0391</td>
</tr>
<tr>
<td>2020</td>
<td>$36.0896</td>
</tr>
<tr>
<td>2021</td>
<td>$34.8931</td>
</tr>
<tr>
<td>2022</td>
<td>$34.6062</td>
</tr>
<tr>
<td>2023</td>
<td>$33.8872</td>
</tr>
</tbody>
</table>
2023 CMS National Fee Schedule
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
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
“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
“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.”
83% of typical ED doc’s RVUs from 99281-99285
8% from critical care
9% from procedures
Drill Down On The 2023 RVUs

2023 RVU Difference By Code For E/M Services

RVUs

99281 99282 99283 99284 99285 99291

0.35 1.24 2.13 3.58 5.21 6.31

1.45 rvu 1.63 rvu 1.10 rvu
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:
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

Level 5 Decrease

Level 4 Increase

Level 3 Decrease
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 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
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**

<table>
<thead>
<tr>
<th>Category</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Constitutional:</strong></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>Patient is not in acute distress.</td>
</tr>
<tr>
<td>Appearance</td>
<td>Normal appearance, but is diaphoretic.</td>
</tr>
<tr>
<td>Comments</td>
<td>Appears uncomfortable</td>
</tr>
<tr>
<td><strong>HENT:</strong></td>
<td></td>
</tr>
<tr>
<td>Head</td>
<td>Normocephalic and atraumatic.</td>
</tr>
<tr>
<td>Eyes</td>
<td>Extraocular Movements: Extraocular movements intact.</td>
</tr>
<tr>
<td>Neck</td>
<td>Vascular: No carotid bruit.</td>
</tr>
<tr>
<td><strong>Cardiovascular:</strong></td>
<td></td>
</tr>
<tr>
<td>Rate and Rhythm</td>
<td>Normal rate and regular rhythm.</td>
</tr>
<tr>
<td>Pulses</td>
<td>Normal pulses.</td>
</tr>
<tr>
<td>Heart sounds</td>
<td>Normal heart sounds. No murmur heard.</td>
</tr>
<tr>
<td><strong>Pulmonary:</strong></td>
<td></td>
</tr>
<tr>
<td>Effort</td>
<td>Pulmonary effort is normal. No respiratory distress.</td>
</tr>
<tr>
<td>Breath sounds</td>
<td>Normal breath sounds.</td>
</tr>
<tr>
<td><strong>Abdominal:</strong></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>Abdomen is flat.</td>
</tr>
<tr>
<td>Palpitations</td>
<td>Abdomen is soft.</td>
</tr>
<tr>
<td>Tenderness</td>
<td>There is no abdominal tenderness.</td>
</tr>
<tr>
<td><strong>Neurological:</strong></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>No focal deficit present.</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Patient is alert and oriented to person, place, and time. Mental status is at baseline.</td>
</tr>
<tr>
<td><strong>Psychiatric:</strong></td>
<td></td>
</tr>
<tr>
<td>Mood and Affect</td>
<td>Mood normal.</td>
</tr>
<tr>
<td>Behavior</td>
<td>Behavior normal.</td>
</tr>
</tbody>
</table>
2023 ED 9928X Codes Will Be Based on MDM Alone!
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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Elements of Medical Decision Making</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99282</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99283</td>
<td>Low</td>
<td>Low</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Category 1: Tests and documents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Any combination of 2 from the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review of prior external note(s) from each unique source*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• review of the result(s) of each unique test*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ordering of each unique test*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>or Category 2: Assessment requiring an independent historian(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td>
<td></td>
</tr>
</tbody>
</table>
Collective Participation: Which of the Following Is True Regarding 2023 Documentation

Which of the below is **True**?

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

**All of the Above Are True**
New ED Guidelines: Code Construct Detail
<table>
<thead>
<tr>
<th>Level</th>
<th>2022 MDM</th>
<th>2023 MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>Straight Forward</td>
<td>None</td>
</tr>
<tr>
<td>99282</td>
<td>Low</td>
<td>Straight Forward</td>
</tr>
<tr>
<td>99283</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>99284</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>99285</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>
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**
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.
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
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
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)

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

Clinically and Coding Relevant:
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**

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

**ED Course**

<table>
<thead>
<tr>
<th>Time</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1600</td>
<td>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]</td>
</tr>
<tr>
<td>1617</td>
<td>CBC noted, 22K, and lactate 2.4. Pt reassessed, BP 105 systolic, HR 110. [ET]</td>
</tr>
</tbody>
</table>

**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:**

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
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
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

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.

HEENT:
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
1. Acute bronchitis, unspecified organism

ED Disposition: Discharge - 2/15/2023 15:16
Condition at time of disposition: Good
Low Acuity Vignette – All the Tools

Progress Notes, Medical Decision Making and Critical Care

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.

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
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.

**Base Case**

**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
<table>
<thead>
<tr>
<th>Level of MDM (Based on 2 of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
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<td>N/A</td>
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<tr>
<td>99282</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 self-limited or minor problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 stable chronic illness</td>
<td></td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td>1 acute, uncomplicated illness or injury</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 stable, acute illness</td>
<td>Category 1: Tests and documents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care</td>
<td>Any combination of 2 from the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 or more self-limited or minor problems</td>
<td>• Review of prior external note(s) from each unique source*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 stable chronic illness</td>
<td>• Review of the result(s) of each unique test*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 acute, uncomplicated illness or injury</td>
<td>• Ordering of each unique test*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 stable, acute illness</td>
<td>Category 2: Assessment requiring an independent historian(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care</td>
<td>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td>
<td></td>
</tr>
<tr>
<td>99284</td>
<td>Moderate</td>
<td>Moderate (Must meet the requirements of at least 2 out of 3 categories)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 or more chronic illnesses with exacerbation, progression, or side effects of treatment</td>
<td>Category 1: Tests, documents, or independent historian(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 or more stable chronic illnesses</td>
<td>Any combination of 3 from the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 undiagnosed new problem with uncertain prognosis</td>
<td>• Review of prior external note(s) from each unique source*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 acute illness with systemic symptoms</td>
<td>• Review of the result(s) of each unique test*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 acute complicated injury</td>
<td>• Ordering of each unique test*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 or more stable chronic illnesses</td>
<td>Assessment requiring an independent historian(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 undiagnosed new problem with uncertain prognosis</td>
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<td></td>
</tr>
<tr>
<td></td>
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<td>Category 3: Discussion of management or test interpretation</td>
<td></td>
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<td></td>
<td>2 or more stable chronic illnesses</td>
<td>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
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<tr>
<td></td>
<td>1 undiagnosed new problem with uncertain prognosis</td>
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<td></td>
<td>1 acute illness with systemic symptoms</td>
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<td></td>
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<td></td>
<td>1 acute complicated injury</td>
<td>Examples only:</td>
<td></td>
</tr>
<tr>
<td>99285</td>
<td>High</td>
<td>Extensive (Must meet the requirements of at least 2 out of 3 categories)</td>
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<tr>
<td></td>
<td>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>Category 1: Tests, documents, or independent historian(s)</td>
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<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>Any combination of 3 from the following:</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Review of prior external note(s) from each unique source*</td>
<td></td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Review of the result(s) of each unique test*</td>
<td></td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Ordering of each unique test*</td>
<td></td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>Assessment requiring an independent Nominator(s)</td>
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<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>Category 2: Independent interpretation of tests</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)</td>
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<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>Category 3: Discussion of management or test interpretation</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
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<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>Examples only:</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Decision regarding elective major surgery with identified patient or procedure risk factors</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Decision regarding emergency major surgery</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Decision regarding hospitalization or escalation of hospital level of care</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
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<tr>
<td></td>
<td>1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>• Parenteral controlled substances</td>
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</tr>
</tbody>
</table>
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.”
<table>
<thead>
<tr>
<th>Component 1 – Problems</th>
<th>Component 2 – Data</th>
<th>Component 3 – Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 4</strong></td>
<td><strong>(Must meet 1 of 3 categories)</strong></td>
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<tr>
<td>Chronic illnesses with exacerbation</td>
<td><strong>Category 1: Tests, documents, or independent historian</strong></td>
<td>Prescription drug management</td>
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<tr>
<td>Undiagnosed new problem with uncertain prognosis</td>
<td>Three from the following:</td>
<td>Decision regarding minor surgery with risk</td>
</tr>
<tr>
<td>Acute illness with systemic symptoms</td>
<td>• Review of prior external notes</td>
<td>Diagnosis or treatment significantly limited by social determinants of health</td>
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<tr>
<td>Acute complicated injury</td>
<td>• Ordering of each unique test</td>
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<td></td>
<td>• Independent historian(s)</td>
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<td></td>
<td><strong>Category 2: Independent interpretation of diagnostic test</strong></td>
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<td></td>
<td><strong>Category 3: Discussion of management or test interpretation with external provider</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Level 5</strong></td>
<td><strong>(Must meet 2 of 3 categories)</strong></td>
<td></td>
</tr>
<tr>
<td>Chronic illnesses with severe exacerbation</td>
<td><strong>Category 1: Tests, documents, or independent historian</strong></td>
<td>Drug therapy requiring intensive monitoring for toxicity</td>
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<tr>
<td>Acute or chronic illness or injury poses a threat to life or bodily function</td>
<td>Three from the following:</td>
<td>Decision regarding hospitalization</td>
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<tr>
<td>Cough</td>
<td>• Review of prior external notes</td>
<td>Decision not to resuscitate or to de-escalate care</td>
</tr>
<tr>
<td>Vague CP</td>
<td>• Ordering of each unique test</td>
<td></td>
</tr>
<tr>
<td>Wheeze</td>
<td>• Independent historian(s)</td>
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</tr>
<tr>
<td></td>
<td><strong>Category 2: Independent interpretation of Diagnostic test</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Category 3: Discussion of management or test interpretation with external provider</strong></td>
<td></td>
</tr>
</tbody>
</table>

**CBC**
**Chemistry**
**Troponin**
**BNP**
**CXR**
**EKG**

**Interp.**
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
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
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!
Michael Granovsky MD CPC FACEP

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