

Survive and Thrive: Overcoming Academic EM Financial Stresses

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Academic Emergency Medicine: Under Financial Pressure

“Academic emergency medicine has come under immense stress with insecure federal funding. We know, however, from the last 50 years, that nothing worthwhile comes easily.”

Andra Blomkalns, MD, MBA; Chair Stanford Department of Emergency Medicine

- Decreased federal grant funding
- GME funding pressure
- All costs increasing (Nurse, tech, staff)
- Medicaid unwinding and work requirements
- Operational constraints: Boarding and LWBT
- Growth in patient complexity
- Expansion of scope of work

OBBA Medicaid Work Requirements Coming Fast

- Medicaid work requirements would require: work, look for work, or conduct another qualifying activity (e.g., education, caretaking) as a condition for Medicaid enrollment.
- Able-bodied adults, aged 19 to 64, without dependents
- Show at least 80 hours per month of work, community service, or participation in a work program; or part-time enrollment in an educational program.
- States must verify individuals' monthly work status every 6 months
- Ramps up January 1, 2027.

Revenue Impacts Mounting

“Payment data from revenue cycle management companies confirm that both insurance administrators and patients regularly underpay or deny payment for significant portions of the allowed amounts they are obligated to pay.”

“Commercial allowed amounts for ED facility care rose 18.65%, while average ED professional allowed amounts dropped 7.42%.”

[2025 Rand Report: Strategies for Sustaining Emergency Care in The United States](#)

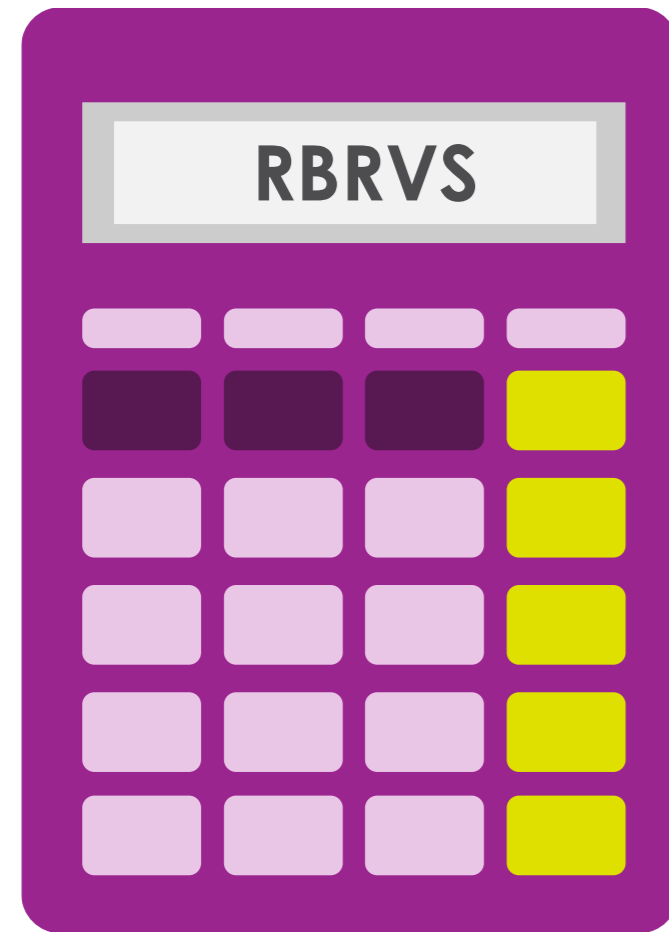




Solutions: Protecting The Safety Net



RBRVS Equation



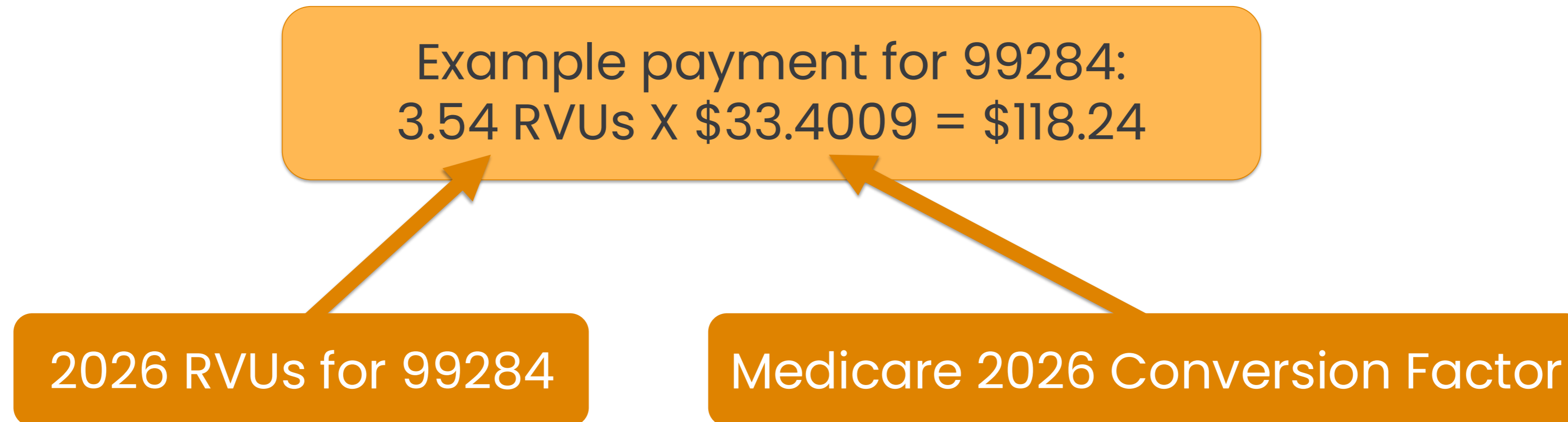
Work RVUs
Practice Expense RVUs
+ Liability Insurance RVUs
Total RVUs for a given code



$$\text{RVU}_{\text{Total}} \times \text{Conversion Factor (CF)} = \text{Medicare Payment}$$

Payment Calculation Example

1. RVUs for a given code
2. Multiplied by the dollars the payer reimburses per RVU
3. Yields physician payment amount



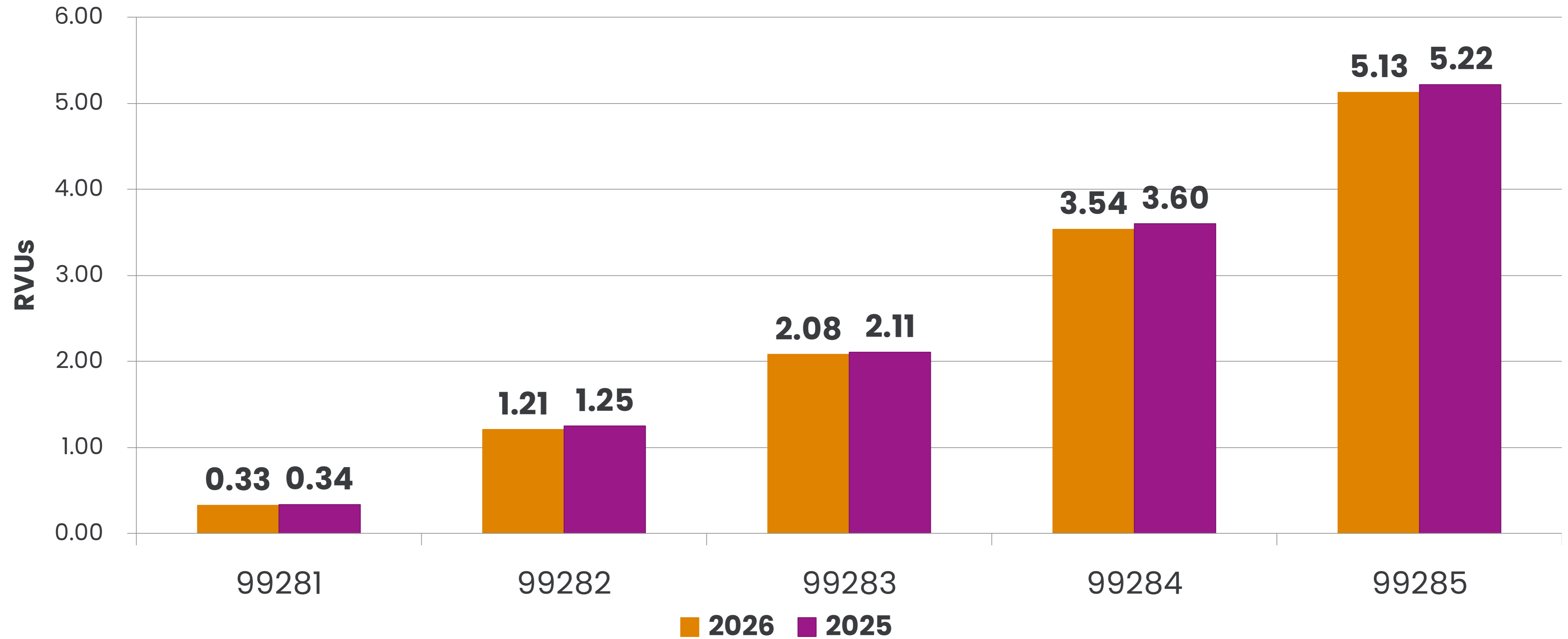
2026 Work RVUs Stable

Code	2024 Work RVU	2025 Work RVU	2026 Work RVU
99283	1.60	1.60	1.60
99284	2.74	2.74	2.74
99285	4.00	4.00	4.00

2026 Total RVUs Small Changes

Code	2024 Total	2025 Total	2026 Total
99281	0.34	0.34	0.33
99282	1.24	1.25	1.21
99283	2.11	2.11	2.08
99284	3.59	3.60	3.54
99285	5.20	5.22	5.13

2026 vs 2025 ED RVUs





2026 Medicare Conversion Factor

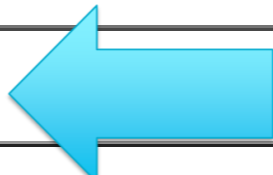

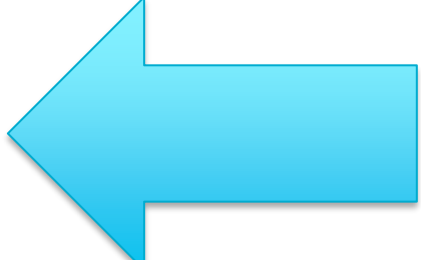
2026 Medicare Conversion Factor

- There are two separate Conversion Factors(CF) starting in 2026:
 - Clinicians participating in Advanced Alternative Payment Models (APMs)
 - Clinicians not in APMs
- The 2025 CF of \$32.3465 updated by three factors:
 1. Statutory Update 0.25% or 0.75%
 2. 2.5% one-year bump from OBBA/HR 1
 3. Budget neutrality positive adjustment +.49%



2026 Conversion Factor

TABLE D-B4: CALCULATION OF THE CY 2026 PFS NON-QUALIFYING APM CONVERSION FACTOR

PFS Non-Qualifying APM Conversion Factor	Percentage	Actual Adjustment	Conversion Factor
Conversion Factor in effect in CY 2025			32.3465
CY 2026 Non-Qualifying APM Update Factor 	0.25 percent	1.0025	
CY 2026 RVU Budget Neutrality Adjustment	0.49 percent	1.0049	
CY 2026 2.50 Percent Increase 	2.50 percent	1.0250	
CY 2026 Conversion Factor			33.4009 

2026 Conversion Factor In an APM

TABLE DB-3: CALCULATION OF THE CY 2026 PFS QUALIFYING APM CONVERSION FACTOR

PFS Qualifying APM Conversion Factor	Percentage	Actual Adjustment	Conversion Factor
Conversion Factor in effect in CY 2025			32.3465
CY 2026 Qualifying APM Update Factor	0.75 percent	1.0075	
CY 2026 RVU Budget Neutrality Adjustment	0.49 percent	1.0049	
CY 2026 2.50 Percent Increase	2.50 percent	1.0250	
PFS Qualifying APM Conversion Factor	Percentage	Actual Adjustment	Conversion Factor
CY 2026 Conversion Factor			33.5675

Is My ED Part of Advanced Alternative Payment Model?

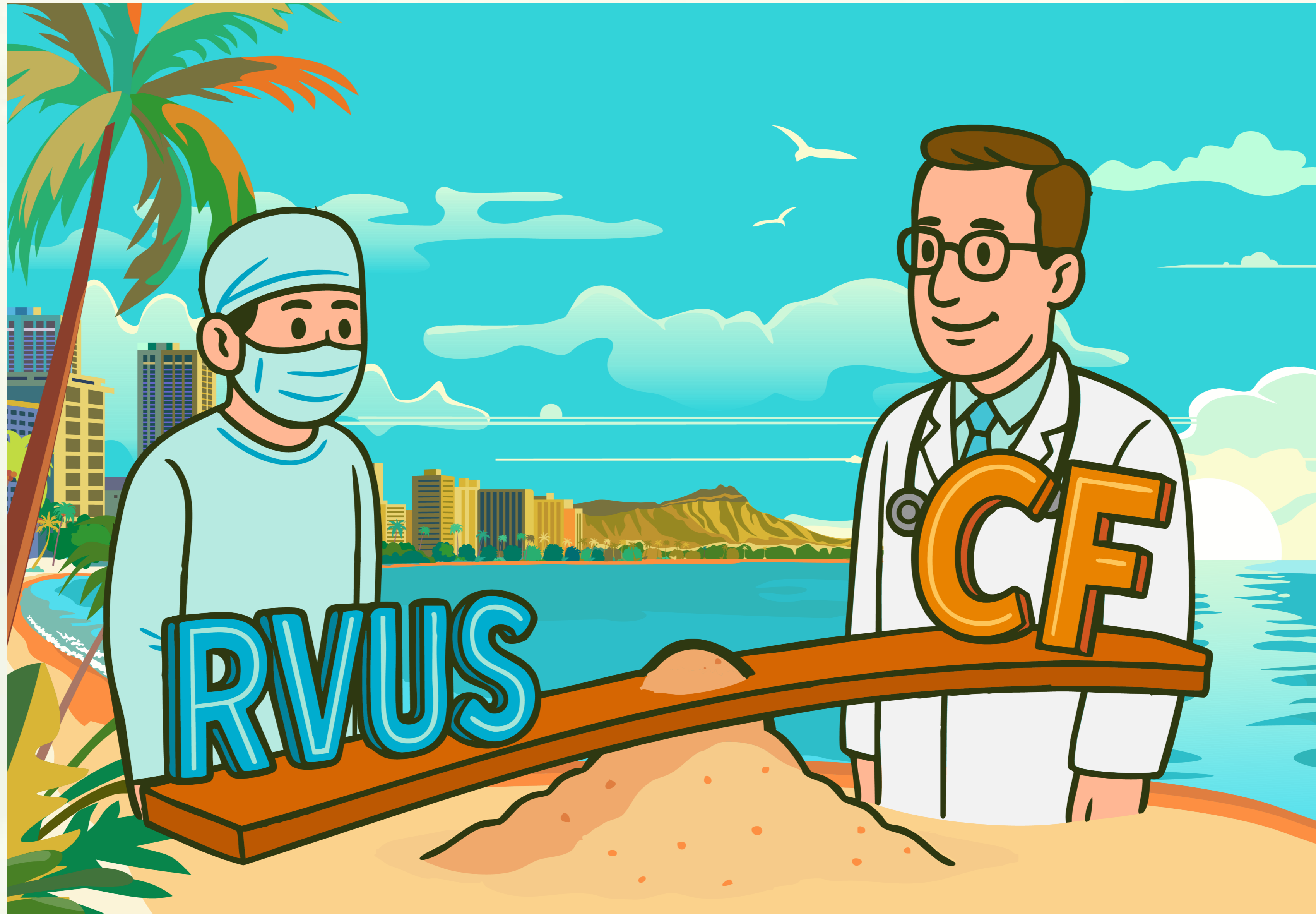
- Can check CMS eligibility
- <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3110/2024-and-2025-Comprehensive-List-of-APMs.pdf>
- 1-866-288-8292 (TRS: 711)
- Email: QPP@cms.hhs.gov
- Self service make your own work ticket:
https://cmsqualitysupport.servicenow.com/ccsq_support_central

2026 Conversion Factor Deeper Dive

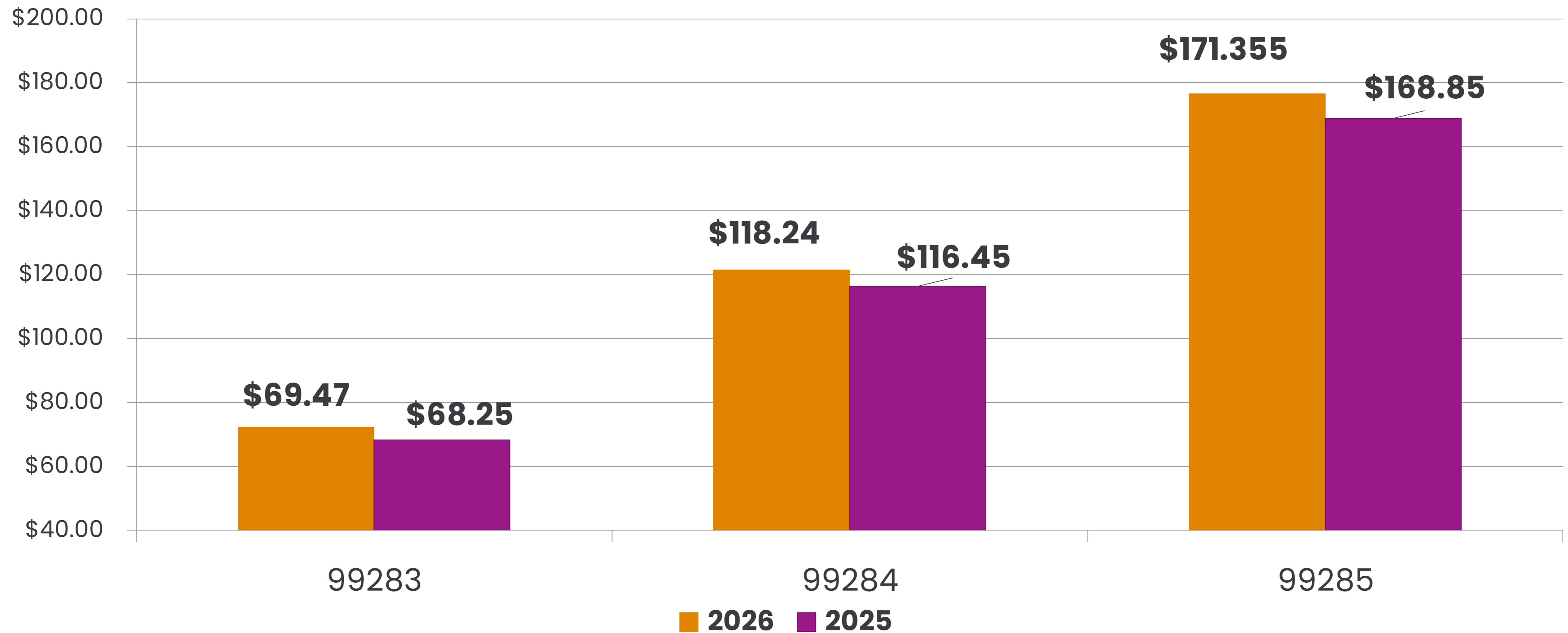
Medicare Physician Conversion Factor (2017– 2026)

Year	CF for QPs	CF	Update QPs (%)	Update (%)
Jan 1, 2017	\$35.8887	\$35.8887	0.24	0.24
Jan 1, 2018	\$35.9996	\$35.9996	0.31	0.31
Jan 1, 2019	\$36.0391	\$36.0391	0.11	0.11
Jan 1, 2020	\$36.0896	\$36.0896	0.14	0.14
Jan 1, 2021	\$34.8931	\$34.8931	-3.32	-3.32
Jan 1, 2022	\$34.6062	\$34.6062	-0.82	-0.82
Jan 1, 2023	\$33.8872	\$33.8872	-2.08	-2.08
Jan 1, 2024	\$33.2875	\$33.2875	-1.77	-1.77
Jan 1, 2025	\$32.3465	\$32.3465	-2.83	-2.83
Jan 1, 2026	\$33.5875	\$33.4009	+3.84%	+3.26%

- The 2026 CF **3.26%/3.84%** increase.
 - Most emergency physicians will receive the 3.26% increase.
- Medicare Economic Index 2026 projected at 2.5%
- This is the first time in 6 years that there is an increase to the CF!
- However, still net negative to pre COVID



2026 vs 2025 Reimbursement Key ED Codes





Optimize Reimbursement

Where Are The RVUs?

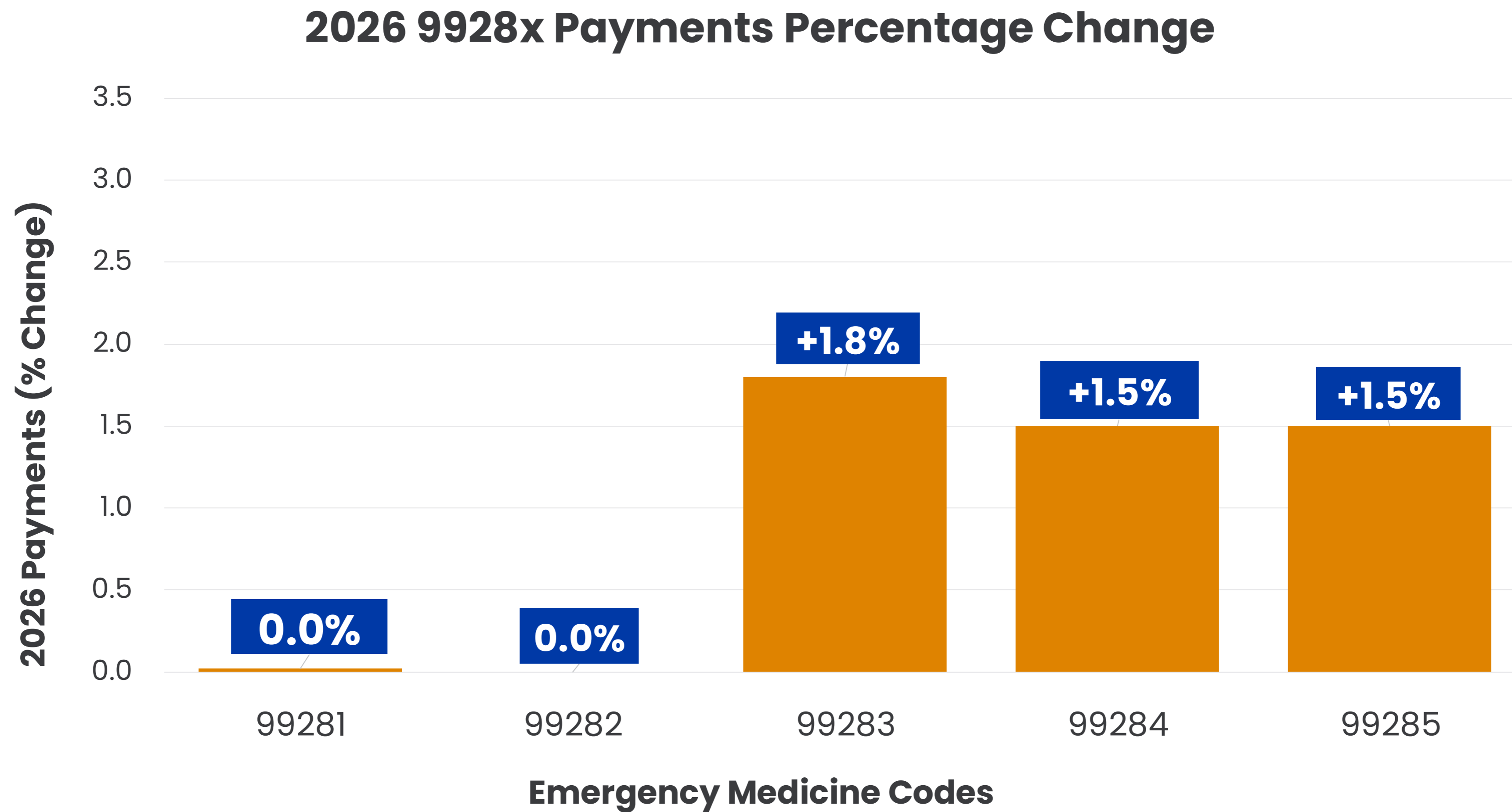
- 83% of typical ED doc's RVUs 99281-99285
- 8% from critical care
- 9% from procedures

Critical Care: 8%
Procedures: 9%

99281-85: 83%

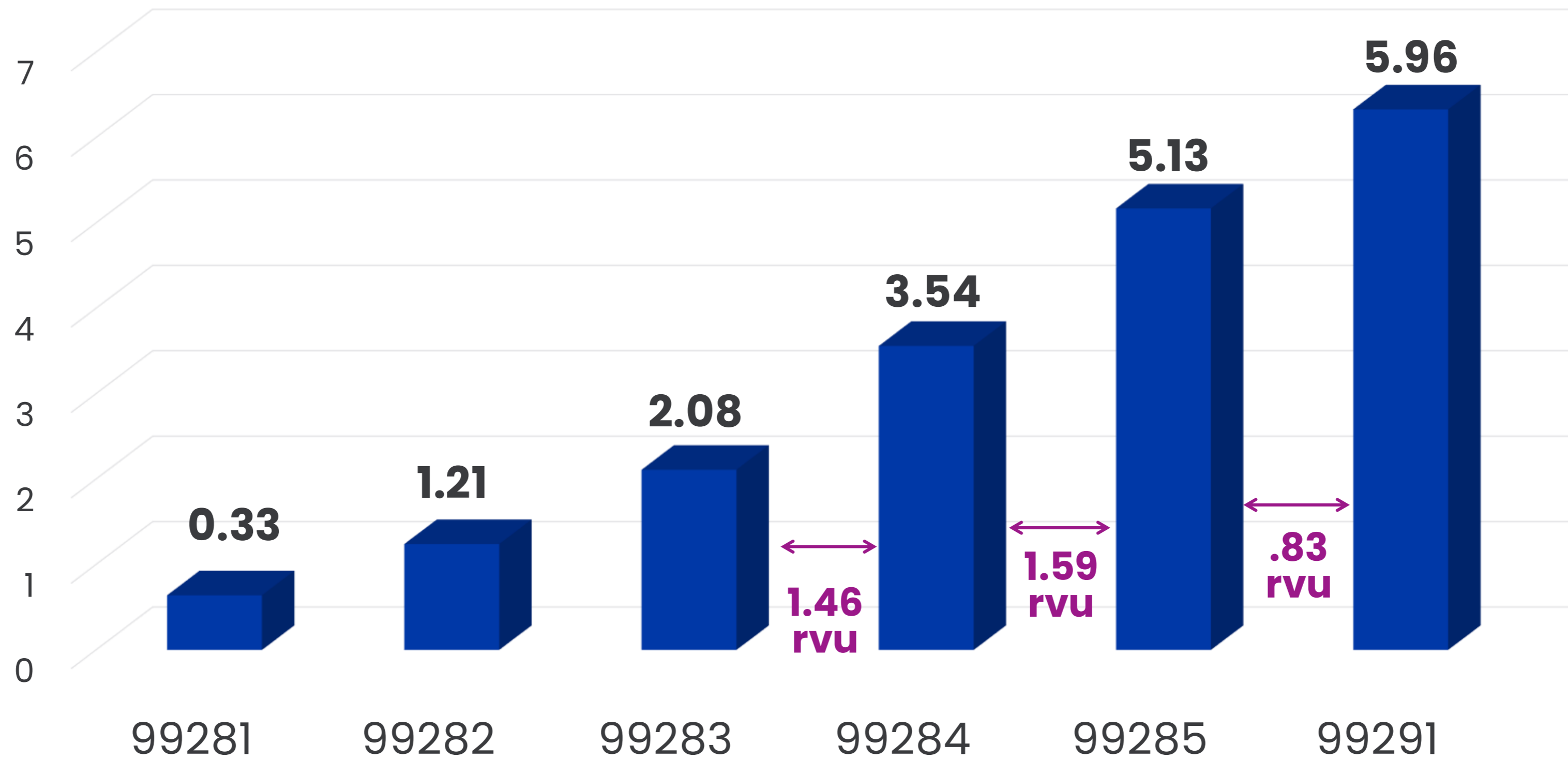


2026 vs 2025 Projected Payments



Drill Down On The 2026 E/M RVUs

**2026 RVU DIFFERENCE BY CODE
E/M SERVICES**





Get The Simple Stuff Right Protect 83% of The RVUs

Key Documentation Elements - Clinical

Complexity:

- Differential diagnosis demonstrates complexity of care
- Pertinent comorbidities that may affect care

Data:

- History obtained from an independent historian (family/EMS)
- Review of external records (inpatient notes, office records, PDMP)
- Discussions of management with other clinicians (hospitalist, consultants, pharmacy, social work)
- Independent interpretations of studies (ECG, x-ray, ultrasound)

Risk:

- Prescription medication and hospitalization performed or appropriately considered
- Care significantly impacted by Social Determinants of Health

Differential Diagnoses and Comorbidities That May Affect Care



48-year-old with a history of HTN, DM, and active smoking presents with 2 days of intermittent chest pain. Episodes last 2-3 minutes, are unrelated to exertion, no associated N/V/diaphoresis/radiation. No recent travel or surgery. No hx of malignancy.

MDM: evaluation for ACS, serial ECG and troponin negative, heart score 3. PERC negative, not consistent with PE.

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

Differential Diagnoses and Comorbidities

Progress Notes, Medical Decision Making and Critical Care .procdoc

Patient is on Eliquis and is describing worsening pain over the last couple of days: given his mechanism and worsening pain, an abdominal CT will be ordered due to the concern for potential liver laceration, splenic laceration, or retroperitoneal bleed.

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

Independent Historian and External Record Review

History of Present Illness

75 y.o. patient BIBA from a nursing home for evaluation of altered mental status x 1 day. History is limited due to acuity.

Independent Historian

According to EMS, pt had a decrease in PO intake x 2 days, developed a fever of 101 this morning. Glucose en route, 140.

ED Course

External Record Review: pt discharged from this facility August 2025, diagnosis, UTI. An echo revealed an EF of 55%.

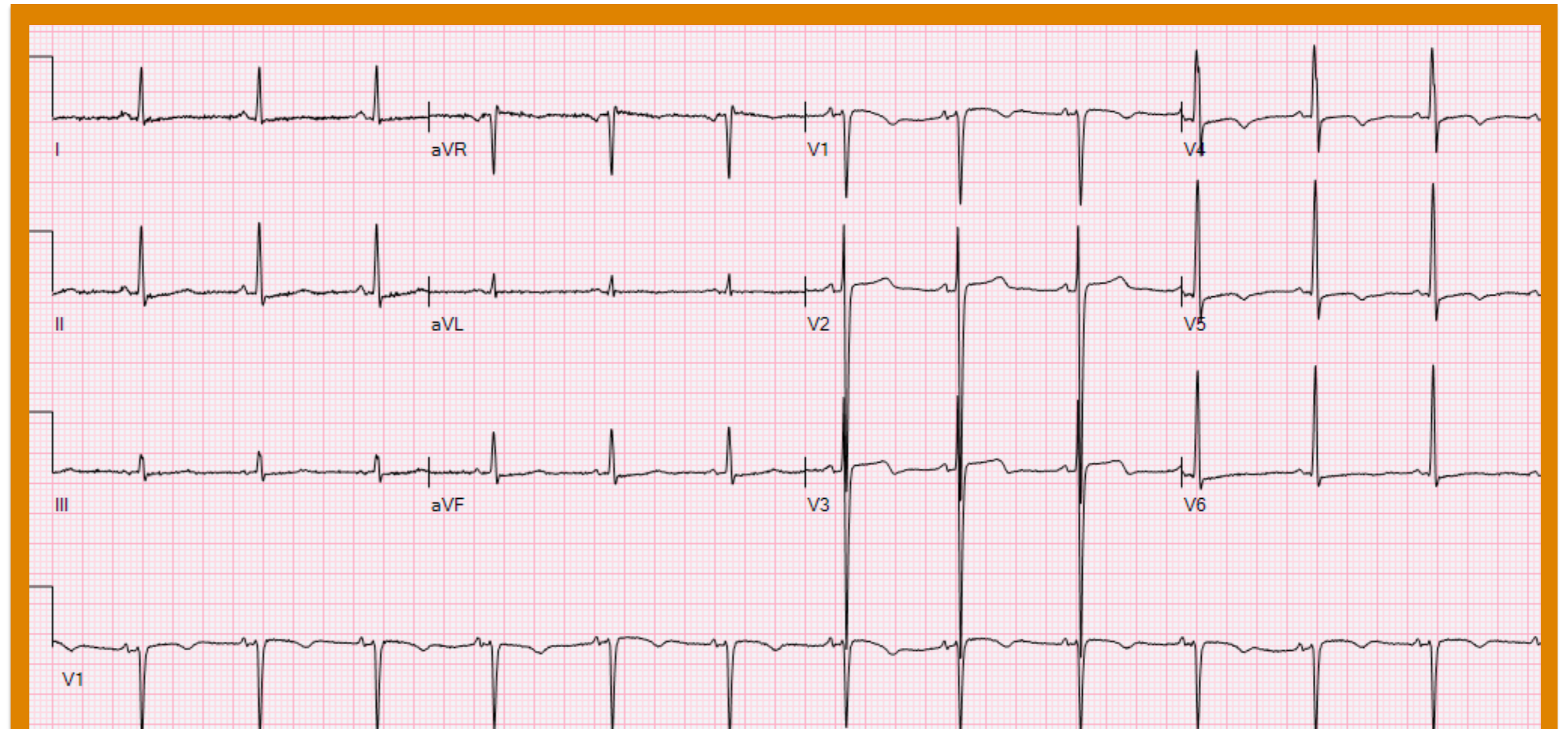
External record review

Concern for sepsis will order 30 cc/kg bolus

Independent Interpretation of Studies

Independent Interpretation
that is clinically meaningful

Does not need to rise to the
level of a billable interpretation
to contribute to the MDM



ECG interpretation:

Normal sinus rhythm, T wave inversion
consistent with inferolateral ischemia

DATA: Discussions

Discussion of management or test with **external physician/other qualified health care professional**/appropriate source

Examples to consider:

- *“I spoke to the **dietician** who recommends when the patient returns to rehab they add a protein supplement for his nutritional state.”*
- *“The **pharmacist** called and we discussed the best antidote for the prolonged INR.”*
- *“The **physical therapist/occupational therapist** assessed the patient and told me they qualify for home health.”*
- *“I spoke with the **Speech therapist** and the patient did not pass the swallow study and should remain npo.”*

No Additional Documentation Required

- **Data elements ordered:**
 - Labs
 - Radiologic studies
 - ECG
- **Risk elements:**
 - Prescriptions given
 - Admission
 - Medications requiring monitoring

“Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter.”

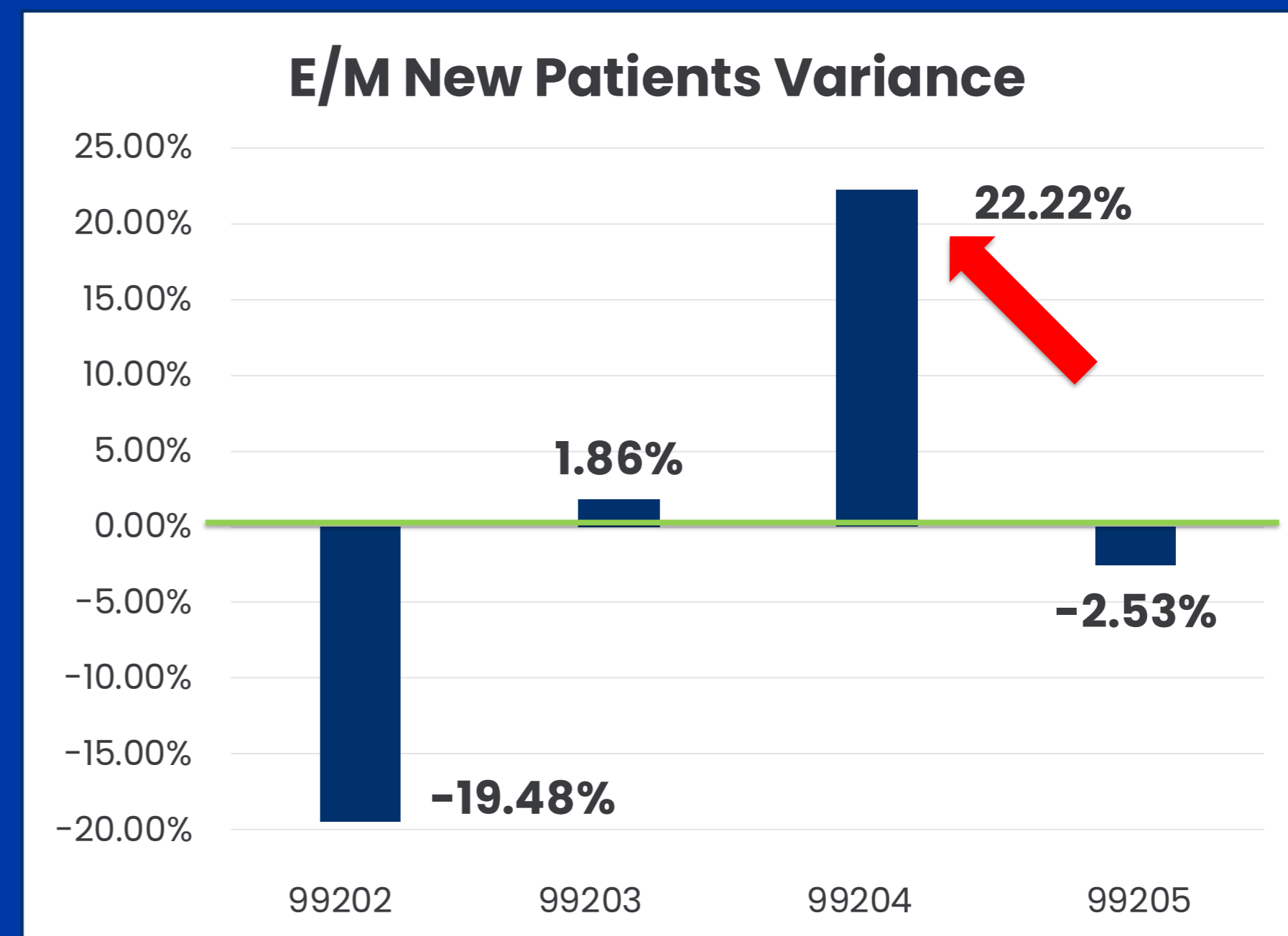
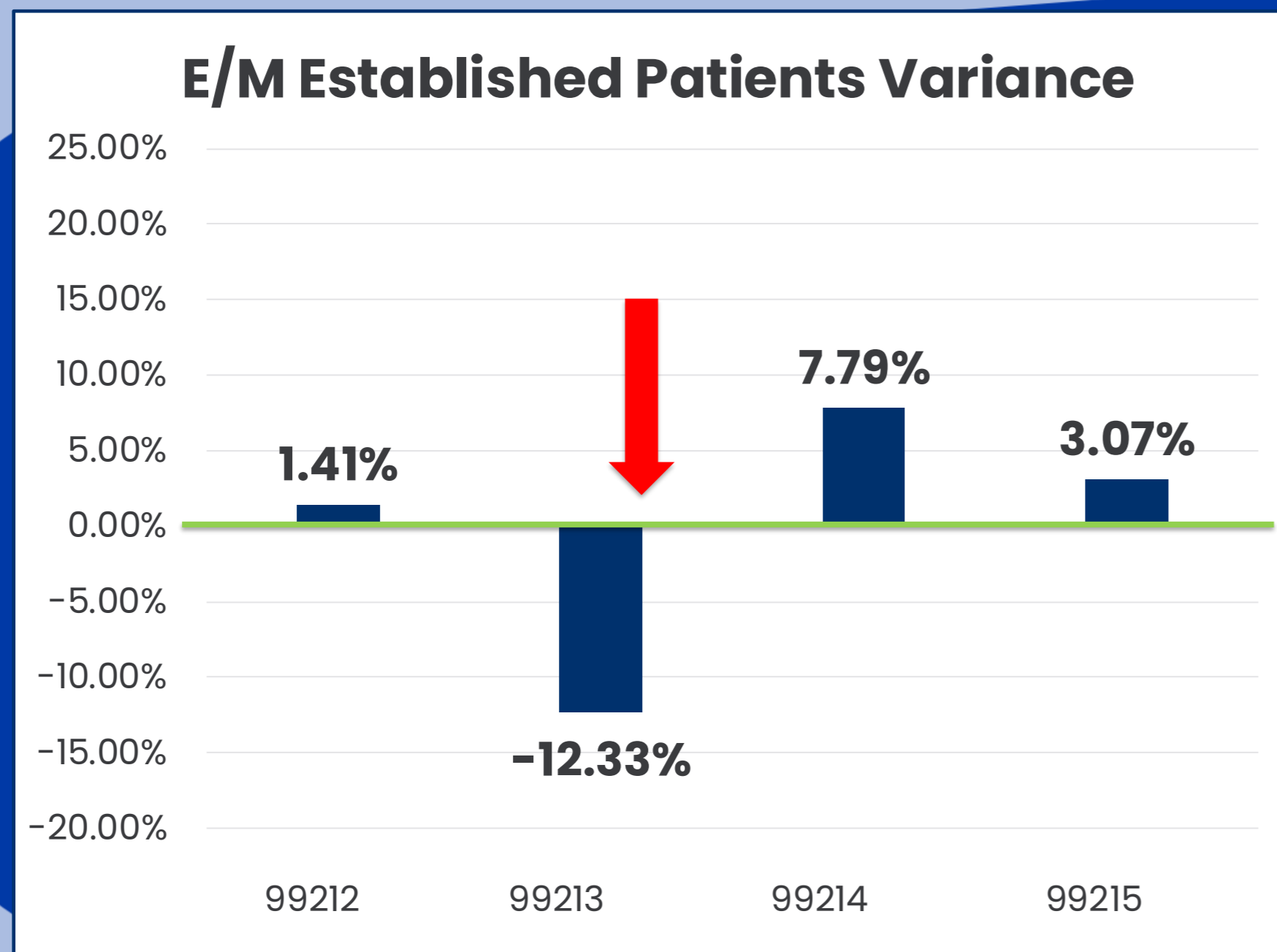
CPT E/M Guidelines

AMA Guidance: Documentation Guidelines Coding Distribution Shift

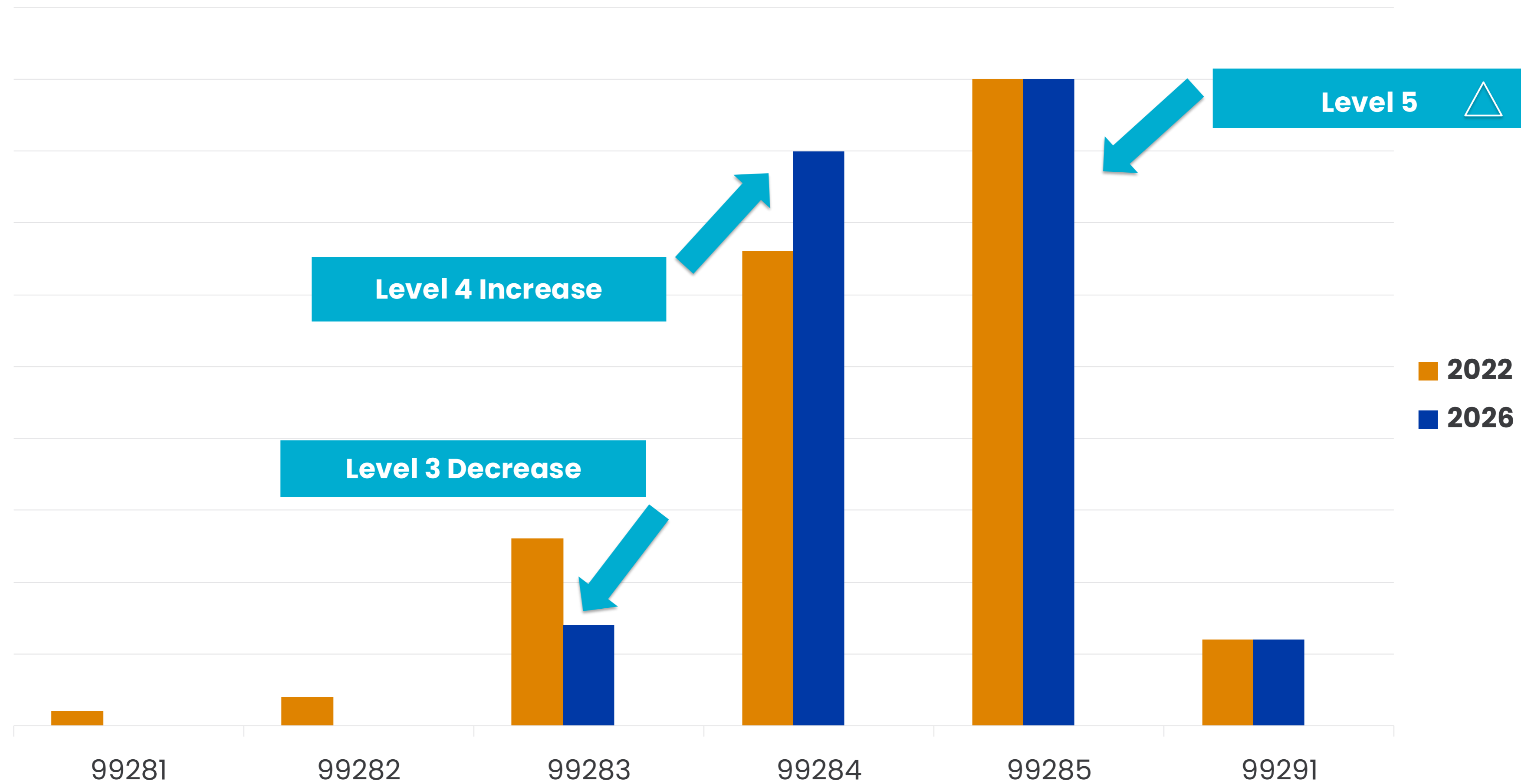


Early Results of Top Performers

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:



2026 E/M Distribution: Get The Curve Right



Don't Forget- Critical Care Under Reported Circulatory: Rapid A-Fib

- Rapid A-fib requiring Cardizem drip
- Medical Decision Making:

62-year-old with history of CABG 2018. Complains of rapid heartbeat with chest pain. EKG shows A-fib with RVR HR 170's-180s BP normal. Given cardizem 20 mg bolus. Rate still 150s with 2/10 chest pain. Additional 10mg bolus given with drip started. Heart rate now 100-110. BP normal CP resolved.

**Hard Findings
Interventions**

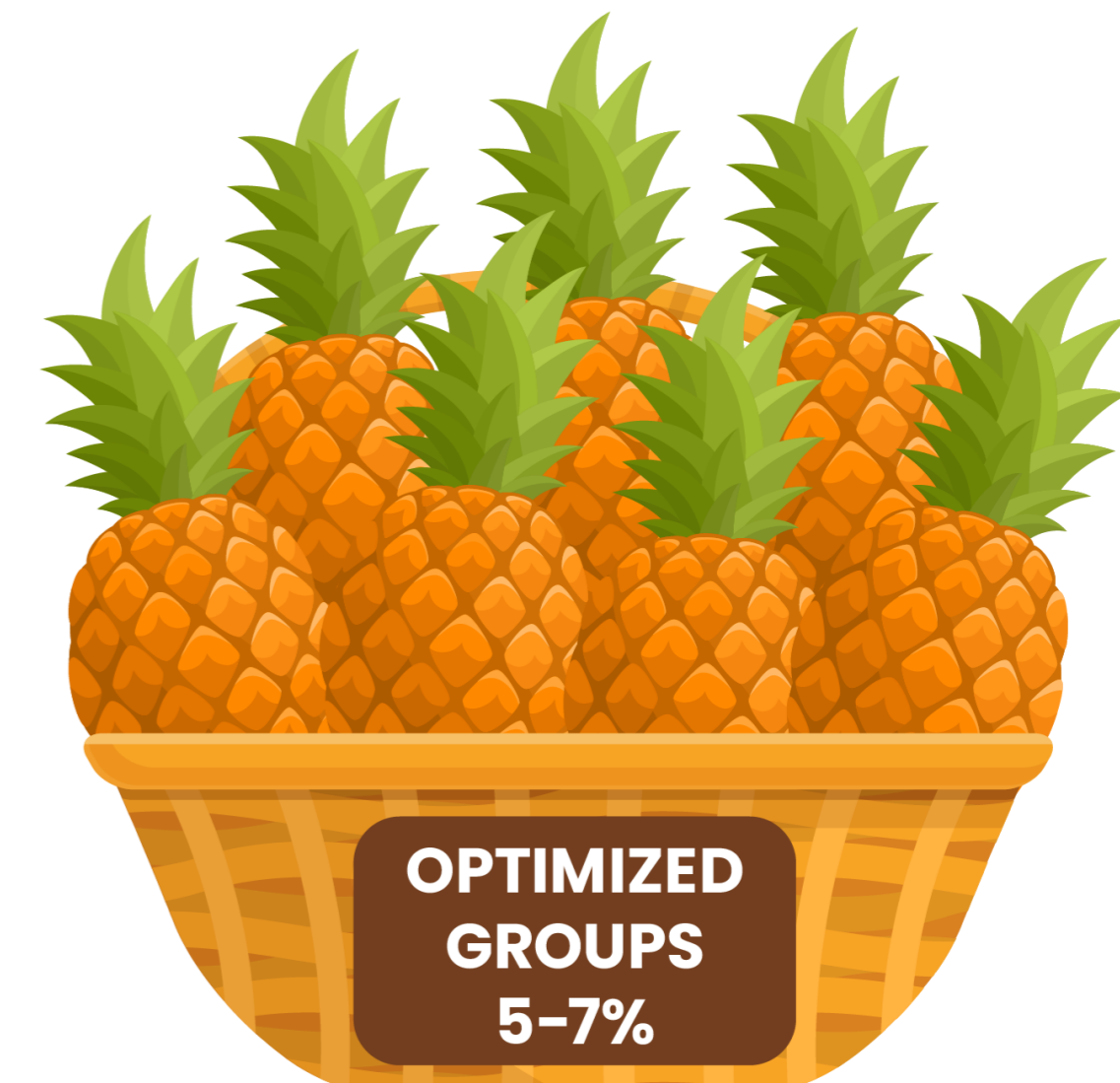


- Clinical Impression: Afib with RVR
- Critical Care Time: 40 minutes, excluding billable procedures

CV: Afib w/RVR, Sx SVT, ACS/active CP or EKG changes, Non Q wave MI

Benchmarking Critical Care

- Most admissions to ICU setting
 - Benchmark ICU admit rate against 99291
- Nationally ~2.5% all payers (under utilized)
 - Optimized groups approach 6–8% all payers
- Medicare Benchmark Data
 - National 8.5%
 - CA(S) 13.2%
 - PR 0.5%





Payers Gone Wild – Protect Your Collections



LANE Analysis

- Low-Acuity Non-Emergent
- Increasingly used by insurers to fully deny or down code legitimate claims
- Identifies avoidable costs and “replacement” costs if care was delivered at an alternate location



MERCER GOVERNMENT
HUMAN SERVICES
CONSULTING

Addressing the Problem of Low Acuity Non-Emergent ED Visits

A Clinical Efficiency Analysis Approach To Influencing Quality Of Care Strategies
and Reducing Avoidable Health Care Costs

1 in 6 Patients!

JAMA
Network | **Open**[™]

Original Investigation | Health Policy

Analysis of a Commercial Insurance Policy to Deny Coverage for Emergency Department Visits With Nonemergent Diagnoses

Shih-Chuan Chou, MD, MPH; Suhas Gondi, BA; Olesya Baker, PhD; Arjun K. Venkatesh, MD, MBA, MHS; Jeremiah D. Schuur, MD, MHS

- Cross sectional analysis using Anthem's non-emergent diagnosis list
- 15.7% of visits were eligible for denial
- Presenting symptoms overlapped with 87.9% of all ED visits

Final Diagnosis Driven Down Codes



February 24, 2026

Subject: Re: Evaluation and Management Services in the Emergency Department

[Redacted]

Thank you for your letter dated February 18, 2026, regarding Highmark's Emergency Department Evaluation and Management (E&M) leveling criteria and the LANE Diagnosis List. We appreciate your engagement and the opportunity to clarify the points you raised.

We have reviewed your "Request for Immediate Action" and would like to address each of your five points:

Immediately suspend automatic Level 3 downcoding tied to the LANE Diagnosis List:

Highmark's downcoding program is designed to prevent the inappropriate billing of low-acuity, non-emergent conditions at a Level 4 or 5. The application of this policy for Pennsylvania will commence on March 30, 2026. This date was established to ensure compliance with regulatory requirements for notification of policy changes. We are committed to moving forward with the implementation of LANE as intended and explained in greater context below.

How to Protect Your Group

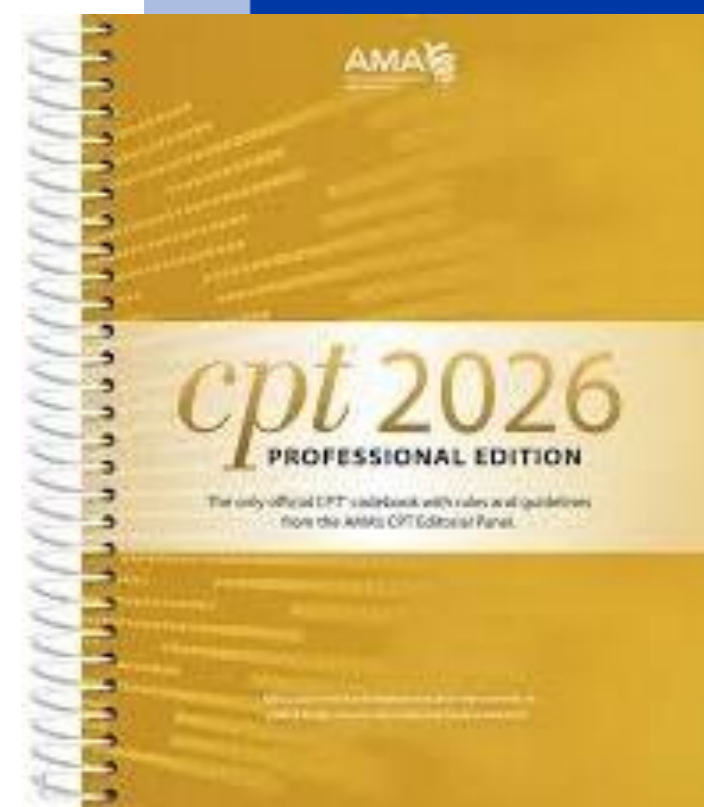
- Do not auto down code yourself
 - Falsely make days in AR better but monthly cash and CPV go down!
- Do not simply let CBO write off claims
 - Cosmetically improve Accounts Receivable Reports and staff work
- EMTALA is still in place
- Prudent layperson supports your treatment
 - 42 C.F.R. § 438.114(a).
 - <https://www.aademrsa.org/advocacy/key-issues/prudent-layperson-standard/>
- Demand human coders not simply AI bots review the records
- Engage with the payers

Defend The Safety Net: Presenting Symptoms Drives Complexity Scoring

“The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid.”

CPT 2023 Documentation Guidelines page 14

CPT 2026 Professional Edition page 17



Conclusion



- We are all facing more financial stress and it is increasing
- RVUs are stable
- Medicare payment going up a little
- Check your E/M distribution- get the coding right
- Make sure CBO is not accepting down codes and denials

Contact Information

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Implementation Calendar

- HHS will review legislation and begin laying out implementation plan.
- Most deadlines are not for years, so there is time for HHS to issue rules and guidance and for states to figure out their implementation strategies.



Selected References



- American Hospital Association. (2024–2025). Reports on hospital financial pressures.
- RAND Corporation. (2024). Strategies for Sustaining Emergency Care in the United States. https://www.rand.org/pubs/research_reports/RRA2937-1.html
- Venkatesh, A. et al. (2023). The Cost-Shifting Economics of U.S. Emergency Department Care. *Annals of Emergency Medicine*.
- Centers for Disease Control and Prevention. National Center for Health Statistics. Emergency Department Visit Statistics.
- Healthcare Financial Management Association. Financial challenges facing hospital emergency departments.
- JAMA Health Forum. Research on emergency department utilization among uninsured populations.
- Health Affairs Scholar. Studies on Medicaid coverage changes and emergency department finances.

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