Illinois EPIC
Emergency Physicians Interim Communique

Illinois College of Emergency Physicians
2001 Butterfield Road Esplanade I, Suite 320
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Volume 4

PRESIDENT'S LETTER

Out With the Old, In With the New?

Jason Kegg, MD, FACEP

As the calendar year for 2022 draws to a close, we here at ICEP hope that this finds you and yours well! What a year it has been! For me, it feels as though it has flown by. I remember that I began the year optimistically hoping for an increased return to "normalcy," the decline of COVID, some relief for our over-burdened hospitals and nursing staff, less bed shortages, and an increased appreciation for all that EM does for the cause of medicine. I can give you one thing on that list, and I hope that it will sustain – appreciation. While you can't unwrap gratitude, or spend it at a store, it is something that you all deserve. My sincere and heartfelt hope is that all of you reading this, whether you are in your first year of practice or your thirtieth year, realize just how much what you do matters. To all of us.

Know that with every patient encounter, every hand you held, every concerning mass newly found on imaging, every adversarial consult call you navigated, every kid that received an ED popsicle, every intoxicated person you fed, every parent or significant other you reassured, every individual you discharged but let sleep in the ED because you knew they had no other place to go, every psychiatric admission that you held in your ED for days awaiting admission, every IV you started or patient you helped to the bathroom because your nurses were understaffed, every prolonged pediatric code that you had to call, every time that your team achieved ROSC, every meal you bought for the ED or potluck to which you contributed, you have made a difference. Hopefully, this list has brought to mind a recent situation or, at the very least, resonates with a formative past experience.

These situations paint the picture of a specialty that sees acute, unscheduled care when other specialties close their offices early for the weekend or remain dark on a holiday. Let me speak proudly and tell you all that, no matter what others think, no one else can do what we do. Our colleagues can presume that we only care about the gory and adrenaline-fueled complaints, but we know that our role is so much more than that. It sounds cliché but we see not only the whole patient, but we also commonly see the bigger picture. When Ortho says that there is nothing to be done surgically for those bilateral wrist fractures and the patient can be splinted and discharged, we see that the patient lives alone, will have no way to care for themselves, and coordinate resources. We see patients on not only their possibly worst days, we also sometimes must give people their worst news. They may not remember our names, but they will remember how we made them feel.

Some of us may be working clinically over the holidays (myself included) but I hope that we can take some time for ourselves and reflect on our impact. Not just our impact over the past several years of the pandemic response but for how much we continue to shore up the house of medicine and remain the safety net poised beneath the fraying tightrope of healthcare. We have served as the front line and the contact point for so many that have no medical home for so long. I was told once that no one wants to talk to us because we create work for someone with every phone call we make. Ironically, the admitting teams don't see the numbers of those for whom we coordinate resources and discharge.

I know that when 2020 ended, many of us fostered the hope that the continued infectious restrictions would be a thing of the past. Perhaps we would finally be able to remove the masks and once again read the facial expressions of our coworkers. As we remain mired in COVID cases, with influenza and RSV thrown in for good measure, maybe we have just gotten better at reading body language and the subtleties in the eyes. I find my comfort in knowing that whatever 2023 brings, we can stand shoulder to shoulder and continue to bolster each other. I look forward to continuing these efforts with all of you and wish you all a healthy, peaceful, restful, holiday season.

— Jason Kegg, MD, FACEP ICEP President

Updates on the Care of Sexual Assault Survivors in Illinois

The Sexual Assault Medical Forensic Services Implementation Task Force was formed to oversee and facilitate the implementation of the 2018 changes to the Sexual Assault Survivor Emergency Treatment Act (SASETA). The last meeting of the Task Force brought numerous updates. Below is a summary of the things most relevant to Illinois emergency physicians.

1. Timeline. As of January 1st 2023 all sexual assault survivors need to be cared for by a Qualified Medial Provider (QMP), who should be available 24/7 within 90 minutes of a patient's arrival to the emergency room. The QMP definition includes Sexual Assault Nurse Examiner (SANE), Sexual Assault Forensic Examiner (SAFE, who is a physician or physician assistant who completed training equivalent to the training of a SANE regarding care of this patient population), or child abuse pediatrician (for pediatric and adolescent patients). Hospitals were supposed to choose a designation and decide if they become Treatment Centers (caring for all sexual assault survivors), Treatment Centers with Approved Pediatric Transfer (caring for survivors age 13 and older and transferring 12 and under to a hospital they have an agreement with) or Transfer Centers. The most recent list of the hospital designations is available on the IDPH website:

   https://dph.illinois.gov/topics-services/health-care-regulation/hospitals/saseta/hospital-listings.html

2. Number of exams performed in Illinois. IDPH has been collecting data from hospitals starting in 2019. Below is a short summary of our statewide numbers:

	Kits offered to all patients	% of kits completed	Kits offered to pediatric (12 and under) patients	% of pediatric kits completed
2019	4470	77	1022	70
2020	3886	75	767	68
2021	4587	72	879	64
First half of 2022	2289	72	424	61

   For your reference, detailed data is available on IDPH website under SASETA data:

   https://dph.illinois.gov/topics-services/health-care-regulation/hospitals/saseta.html

3. Review of programs by IDPH. All hospitals can be audited by IDPH looking for compliance with SASETA. Common and numerous deficiencies found in Treatment Hospitals and Treatment Hospitals with Approved Pediatric Transfer included: incomplete documentation, not offering a kit, not offering a shower, not distributing the required brochures, not obtaining a voucher/not having a copy of the voucher in the chart, non-compliance with mandatory 2-hour staff education, incomplete past gynecological history for survivors, missing follow up information for the patients. Deficiencies in Transfer Hospitals included not notifying DCFS or law enforcement, billing the survivor and not offering services of an advocate. If needed, there are resources summarizing the SASETA requirements on the IL Attorney General Website/Task Force under Educational Materials:

   https://illinoisattorneygeneral.gov/victims/saimplementationtaskforce.html

4. SANEs in Illinois. Since the new SASETA changes, the number of SANEs significantly increased, although it is still work in progress.

	Estimated practicing adult and adolescent SANEs	Estimated practicing pediatric and adolescent SANEs
2018	187	23
2019	234	26
2020	350	43
2021	400	54
2022	475	66

5. Legislative changes

- Public Act 102-0699
  Increased compensation from the Department of Healthcare and Family Services for sexual assault exams for Medicaid and uninsured patients. Starting 7/1/22 hospitals are compensated $1000 per exam, which is a significant improvement over previous <$100 compensation

  For more details and billing requirement see information on DHFS website:

  https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn220705b.aspx

- Public Act 102-1096
  As of 1/1/23 amends the Illinois Criminal Code to specify that a person is not able to give consent when intoxicated, even if the assailant did not provide the intoxicating substance, closing the previous loophole and increasing chances of successful prosecution

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- Public Act 102-1097
  As of 1/1/23 it allows survivors who are non-primary insurance holders to opt out from billing private insurance, extends the voucher for follow up care from 90 to 180 days and regulates care of sexual assault survivors in Federally Qualified Health Centers

  Please note that two of these three laws were conceived, developed, lobbied and drafted by ICEP together with Illinois State Medical Association, Illinois Coalition Against Sexual Assault, multiple SANE programs and advocate organizations, as well as Illinois hospitals and medical systems including Advocate Aurora, AMITA Health, Comer Children's Hospital, Cook County Health, Edward-Elmhurst Health, Howard Brown, Lurie Children's Hospital, Northwestern, and Rush Health System. If you are interested in changing laws to better help ED patients and physicians, please join us in the ICEP Patient and Physician Advocacy committee!

  - Monika Pitzele, ICEP Representative on the Sexual Assault Medical Forensic Services

Pictured above: EM doctors, including Monika Pitzele, MD, FACEP, helping Governor Pritzker sign SB3023 into law in June 2022.

CMS Proposes to Streamline the Prior Authorization Process: Potential Effects on You and Your Patients

There is an across-the-board disdain in medicine for the increased use of prior authorization by insurance companies. I don't think a single physician actually believes that this bureaucratic process for controlling and potentially limiting "unnecessary" services is good for patients nor benefits the health care system in general. Instead, it is simply an administrative nuisance that has contributed to physician burnout and has harmed patients by needlessly delaying their access to vital services.

In the emergency department (ED) setting, one often doesn't think about prior authorization, as fortunately, health insurers are legally prohibited from using prior authorization when patients are experiencing medical emergencies. Nevertheless, prior authorization still has a significant impact on you as emergency physicians and the patients you serve.

Many of you have probably experienced a scenario where the patient you are treating in the ED was unable to receive services in other care locations because of a prior authorization denial and came to the ED specifically to receive those services (sometimes at the direction of their primary care physician or a specialist). In this not-so-unique situation, patients (and their referring physician) recognize that they can receive the service easier at the ED without undergoing prior authorization. This clearly is not an appropriate reason for a patient to receive treatment in the ED, but it reflects a fundamental flaw in the health care system resulting from extremely stringent prior authorization protocols.

Prior authorization also affects ED care by contributing to ED boarding. As described in a previous Regs and Eggs blog post, ED boarding is at crisis levels, and ACEP and 34 other organizations wrote a letter to President Biden asking his Administration to convene a summit on this issue with all impacted stakeholders so that we can together collaborate on near- and longer-term solutions.

ACEP has heard from many of our members that health plans are requiring prior authorization before a patient can be transferred from the hospital to a post-acute facility, like a skilled nursing facility. A key stakeholder in the ED boarding crisis, the American Hospital Association (AHA), has heard the same thing. Back in March 2022, the AHA pointed out in a letter to the Centers for Medicare & Medicaid Services (CMS) that the use of prior authorization among Medicare Advantage (MA) plans was clogging up inpatient beds. As the AHA states, the use of prior authorization is "especially problematic when general acute-care hospital beds have been filled to capacity and while healthcare providers contend with the demands of vaccine distribution and workforce shortages." The continued use of prior authorization has also "resulted in unintended consequences for patients who were then forced to stay in acute care settings unnecessarily while waiting for health plan administrative processes to authorize the next steps of their care."

The AHA asked CMS in the letter to prohibit MA plans from conducting prior authorization at least during the remainder of the COVID-19 pandemic. Well, that didn't happen, and hospitals have become even more filled with patients since then, which in turn has caused longer ED wait times and more boarding in the ED, as individuals have to wait for extended periods (multiple days or even longer) for inpatient beds to become available. And throughout this whole time, MA plans continue to utilize the same prior authorization tactics they have always used—delaying appropriate transfers and causing a ripple effect that has significantly diminished hospitals' capacity and your ability to treat patients.

ACEP believes that CMS should in fact prohibit MA plans from requiring prior authorization in order to transfer patients to post-acute facilities and believes that policy could be one short-term solution that could help address the boarding crisis. However, implementing such a policy does not seem to be in the cards for CMS at this moment.

What CMS is focusing on is streamlining the prior authorization process (which is definitely better than nothing!)—and just last week, CMS released a long-awaited proposed regulation that would accomplish this goal. The health policy community has been waiting for this reg to drop, as it could cut in half the Congressional Budget Office's (CBO's) projection for legislation (which we support!) that would create an electronic prior authorization process for MA plans.

Before describing the proposed reg, let me briefly outline what's in the legislation, the "Improving Seniors' Timely Access to Care Act of 2021." Along with creating an electronic prior authorization process, the legislation would also:

Streamline and standardize the prior authorization process for routinely approved services and give clinicians greater access to criteria for prior authorization determinations;
Require MA plans to compile annually and publish publicly: (1) a list of services subject to prior authorization; (2) rates of initial approvals and successful appeals; and (3) time delays resulting from prior authorization; and
Adopt MA beneficiary protections via federal rule making to improve PA transparency, identifying services with high approval rates, providing continuity of care when changing coverage, and ensuring that PA programs adhere to evidence-based guidelines.

The bill passed the U.S. House of Representatives on September 14, 2022. However, one hold-up that has prevented the bill from being considered by the U.S. Senate has been the CBO score. The CBO estimated in September 2022 that the bill would increase federal spending by $16 billion over ten years. This price tag is significantly more costly than what the bill's sponsors and the physician community had expected. CBO justifies the estimate by stating that the bill would "result in a greater use of services" by creating "additional requirements on plans that use prior authorization." Since CMS is already taking care of some of these additional requirements (including requiring an electronic prior authorization process) on the regulatory side, stakeholders believe that the CBO's cost estimate will likely decrease. A lower CBO cost estimate may pave the way for Senate passage of this critical legislation.

Continued on the next page.

Now, let's get down to what's in this new CMS proposed reg. In short, CMS is requiring certain payors (health insurers) to implement an electronic prior authorization process, shortening the time frames for these payors to respond to prior authorization requests, and establishing policies to make the prior authorization process more efficient and transparent. The impacted payors include MA plans, state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans and CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs).

Specifically, these impacted payors would be required to build and maintain a FHIR API (a platform or application) that would "automate the process for providers to determine whether a prior authorization is required, identify prior authorization information and documentation requirements, as well as facilitate the exchange of prior authorization requests and decisions from their electronic health records (EHRs) or practice management system."

CMS is also proposing to require impacted payors to include a specific reason when they deny a prior authorization request and to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests. CMS, however, is also seeking comment on alternative time frames with shorter turnaround times, for example, 48 hours for expedited requests and five calendar days for standard requests.

Furthermore, CMS proposes to require these payors to implement standards that would enable data exchange from one payor to another payor when a patient changes health plans. Impacted payors must also publicly report certain prior authorization metrics on their website.

Payors will have plenty of time to implement these prior authorization requirements. If finalized, the policies wouldn't take effect until January 1, 2026, with the initial set of metrics proposed to be reported by March 31, 2026.

While all these requirements would fall on payors (rightly so), there is one additional requirement that CMS is imposing on physicians. To encourage physicians to adopt the electronic prior authorization processes, this reg would also add a new measure under the Promoting Interoperability performance category of the Merit-based Incentive Payment System (MIPS). Under this proposal, clinicians would be required to report the number of prior authorizations for services that are requested electronically from an API that a payor establishes. Most emergency physicians are exempt from this category of MIPS, so I don't think this particular policy will have a big impact on you.

Finally, the reg includes five requests for information, focused on:

Accelerating the Adoption of Standards Related to Social Risk Factor Data
Electronic Exchange of Behavioral Health Information
Improving the Electronic Exchange of Information in Medicare Fee-for-Service (FFS)
Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)
Advancing Interoperability and Improving Prior Authorization Processes for Maternal Health
Overall, ACEP is extremely pleased with this proposed reg, and we hope that CMS moves forward with these policies. Although the effective date of the policies seems far away (2026), we urge payors to start implementing these changes to their prior authorization process as soon as possible. We also hope that the legislation does indeed push the Senate to pass the "Improving Seniors' Timely Access to Care Act of 2021" and get that bill signed into law.

Comments on the proposed reg are due on March 13, 2023, and ACEP will be reviewing the proposals in greater detail and providing a comprehensive response. If you have any input on the reg or feedback on how prior authorization is affecting your practice and your patients, please reach out to me at jdavis@acep.org.

Before concluding, I want to report some late breaking news. Yesterday, CMS issued another proposed reg that addresses prior authorization—this one specifically targeting MA plans. Among other provisions, CMS makes it clear that MA plans CANNOT DENY coverage for services that are covered by Traditional Medicare (which is good!). However, the agency still allows prior authorization to take place in most instances (except for emergencies)—which, unfortunately, will continue to DELAY necessary care. With respect to the issue of transferring patients from hospitals to post-acute facilities that I discussed earlier, CMS states that MA plans cannot deny a transfer if the post-acute services a patient would receive align with Traditional Medicare coverage criteria. However, CMS still says that prior authorization is allowed in these circumstances to "ensure items and services meet Medicare coverage rules; it simply limits the coverage criteria that an MA organization can apply to deny an item or service during those reviews." This policy isn't perfect, as prior authorization will still slow down the transfer of patients from hospitals to post-acute facilities—but it is a good start, as MA plans can no longer use inexplicable excuses to initially deny a transfer.

Also of note, the new reg reiterates current law that prohibits MA plans from using prior authorization for emergency services and clarifies that the definition of an emergency includes both physical and mental illnesses. This proposal is important as it makes crystal clear that MA plans cannot require prior authorization if a patient is having a mental health medical emergency.

ACEP will review the MA plan proposed reg in more detail over the coming days, so stay tuned for a more in-depth analysis.

Written by: Jeffrey Davis, Director of Regulatory and External Affairs at ACEP

A Word from the New Executive Director

Bailey A. McMurray, IOM, MAOL

Hello ICEP Community!

I am excited to introduce myself as the new Executive Director of ICEP! Following in the amazing footsteps of Ginny Kennedy Palys, JD, I look forward to leading the talented dynamic ICEP team and working the Board of Directors, volunteers, members, and YOU to advance emergency medicine and elevate the experience of our emergency physician community.

I am dedicated to supporting and guiding your member experience through education, advocacy, innovation, and collaboration to be impactful, inspirational, and resourceful. No matter where you are in your career, I hope that ACEP and ICEP continue to be your professional home.

My passion for community, leadership, and service are at the core of everything I do. I have been inspired by my parents (Mom a Pediatric RN and Dad a Certified Medical Dosimetrist) who always put patient care and creating compassionate experiences at the forefront of their respective careers.

I received my Bachelor of Arts in Mass Communication/Media from Illinois State University and Master of Arts in Organizational Leadership/Non-for-Profit Management from Lewis University. Earlier this year, I graduated from the US Chamber of Commerce Foundation's Institute for Organization Management and received the recognition of IOM.

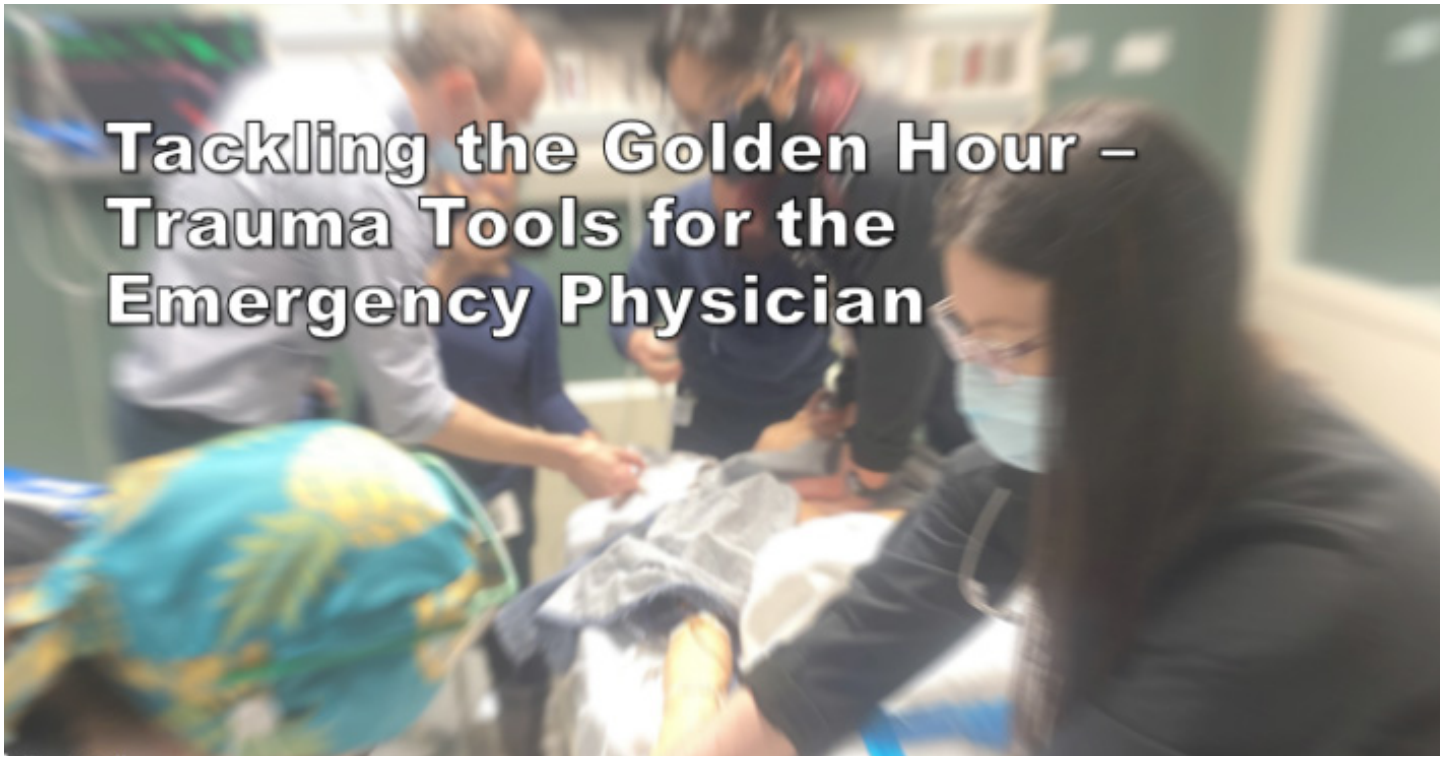
I have over ten years' experience in association and nonprofit management working for fellow healthcare organizations including the Orthopedic Research Society and American Dental Hygienists' Association. I am an active volunteer in several local and professional organizations currently serving as a member of the Component Relations and Volunteer Management Advisory Council for the American Society of Association Executives (ASAE), Membership Committee Chair for the Illinois Alliance for CME (IACME) and oversee various tasks for my family run non-profit.

Please do not hesitate to reach out to myself or the ICEP team directly. I look forward to connecting with you and meeting you either in-person or virtually.

Need to contact Bailey?
Phone: (630) 495-6400, ext. 204
Email: baileym@icep.org

Please refer to our staff directory page on the ICEP website for additional contact information.

Free CME Program on Tackling the Golden Hour



ICEP is pleased to present this free CME activity for members, Tackling the Golden Hour – Trauma Tools for the Emergency Physician is an internet enduring activity that will take approximately 4.25 hours to complete in its entirety.

Certificates will be sent out prior to verification of membership.

This activity was released on July 15, 2022 and the accreditation period expires on June 30, 2025.

Program Description:

Trauma is a significant global health issue, leading to more than 4.6 million deaths annually worldwide. In the United States, injury is the primary cause of death in people ages 1 to 44 years, and the fourth leading cause of death overall. Trauma does not discriminate. Patients with a significant mechanism of injury, at the extremes of life (pediatrics and geriatrics), and with medical co-morbidities and polypharmacy are at increased risk of hemorrhage, shock, and mortality. This program will provide updates on relevant clinical topics regarding trauma care for Emergency Medicine physicians to guide their management and care of these critical patients.

The program includes:

- 4 narrated PowerPoints
- 4.25 hours of *AMA PRA Category 1 Credits*™ continuing medical education

To receive CME, you must:

1. Read and agree to all activity information on this page.
2. Read and agree to all activity front matter/ information on this page.
3. Participate fully in educational content to include listening to or reading lecture material in its entirety
4. Complete activity evaluation.
5. Attest to completing the activity according to the steps referenced above.

Full information and instructions can be found here.

Once participation is successfully verified, ICEP will forward a CME certificate of completion within 14 working days. Please note that *AMA PRA Category 1 Credits*™ may be awarded one (1) time in conjunction with your purchase during the 1-year period.

ICEP offers free CME for state-mandated programs. For all available CME programs head over to icep.org and click on “shop” in the top right hand corner.

$1.5 Million Available in New EMF Grants!

New grant opportunities cover a wide range of critical EM research topics, including 7 new grant categories.

January 20, 2023 Deadline

Medical License Fees Waived for 2022

During his budget address in February, Governor Pritzker's announced that 2022 licensure fees would be waived for front line healthcare workers, including physicians. The waiver was an expression of thanks for critical services that were provided during the Covid pandemic.

In addition, individuals who are not currently licensed in Illinois and are seeking licensure in an eligible profession during the next two budget years will not pay the application fee.

The next deadline for physicians to renew their licenses in the three-year cycle is July 31, 2023. The Illinois Department of Financial and Professional Regulation (IDFPR) estimates that their online renewal portal will open in early April 2023.

Other frontline healthcare professionals eligible for the fee waiver are:

- Nurses (Registered Nurses, APRNs, APRN Controlled Substance, Full Practice APNs, Full Practice APN Controlled Substance, and LPN's)
- Pharmacists
- Pharmacy Technicians
- Physician Assistants
- Social Workers

Click here for the Frontline Healthcare Worker Fee Waiver FAQs.

ICEP Asks for Your Help and to Share Your Stories!

It's time to take action on violence in the ED, and ICEP will lead the way with a new legislative initiative. And you can help!

We need personal stories of violence which affected you (or your colleague healthcare workers, including nurses, techs, and all the staff) in the ED. They don't need to have names (they definitely shouldn't have patient identifiers), but they should have detail.

Your experiences matter to lawmakers! We need as many real-world data as possible as we push to craft and pass legislation with real, meaningful change to improve our working lives in the ED. Violence to ED staff is not acceptable, ever.

Please note that your responses are completely anonymous. Any information shared that could be potentially identifying will be redacted and ensure you are protected.

Share your story here.

Have An Article or Story You Want to Share in the Next EPIC?

ICEP's EPIC newsletter is released quartly. If you have an article or story that you would like to be published that you think would be beneficial to other ICEP members reach out to our Marketing Manager, Brittney Tambeau at brittneyt@icep.org.

Are you prepared for the significant documentation changes coming for 2023?

As many of you probably know, the American Medical Association (AMA) has released Current Procedural Terminology (CPT) documentation guideline changes for all evaluation and management (E/M) services. While the guideline changes began applying to the office and outpatient E/M services in 2021, they will kick into effect for other E/M services, including emergency department (ED) E/M services, starting in 2023.

I don't need to tell you how big a deal this is (but I will anyways!). These documentation guidelines help determine what level of ED E/M service you as emergency physicians should pick for a given ED visit. The ED E/M codes are the "bread and butter" of codes that you bill (85 percent of the time!). Thus, any change to the guidelines not only affects (obviously) how you go about documenting a visit, but also could have a significant impact on your revenue.

This is truly a once-in-a-generation occurrence, as these guidelines haven't been updated since the 1990s. And just as with other policy changes that impact emergency physicians, ACEP has been at the forefront of helping not only to shape the modifications themselves, but also to help the emergency medicine community understand them all.

First, from an advocacy perspective, ACEP had a voice in the CPT and Relative Value Scale (RVS) Update Committee (RUC) decision making processes when these documentation guideline changes were being discussed. We were able to successfully convince a Joint CPT/RUC Workgroup that time should not be a descriptive element for choosing ED levels of service. As I have stated before, it is nearly impossible to measure the time a service takes to complete in the ED. Further, the time spent with a patient in the ED does not necessarily dictate the intensity of the service being delivered.

ACEP was also able to ensure that all five levels of the ED E/M services (levels 1-5, CPT codes 99281-99285) remained untouched. In other words, even though there are changes to how you document each ED E/M service, the actual codes are the same. Eliminating or combining certain codes could have had even more of an impact (and perhaps a deleterious one) on your overall reimbursement.

Now, on to the efforts ACEP has taken to educate our members about the changes. Soon after the documentation guideline changes were released, ACEP offered a special briefing web conference on July 12, 2022. That four-and-a-half-hour conference featured an in-depth review of the 2023 changes with special emphasis on both physician documentation requirements and coder training for extracting those elements, along with real-world emergency department case studies to illustrate that content. David McKenzie, ACEP's Reimbursement Director, and ACEP member Michael A. Granovsky, MD, FACEP, CPC, also wrote an ACEPNow article in September highlighting the major changes and what they mean for you.

However, we have heard a lot of feedback from many of you that you need additional information about exactly what changes are being made. I am happy to announce that last week, ACEP published a comprehensive set of frequently asked questions (FAQs) that were developed by billing and coding experts within ACEP's Coding and Nomenclature Advisory Committee (CNAC).

While I won't ruin all the fun you will have reviewing these FAQs, I do want to mention some key points:

The most significant revision to the 2023 E/M guidelines is the elimination of history and physical exam as elements for ED E/M code selection. Beginning in 2023, the ED E/M services will be based only on medical decision making (MDM).

It is important to note that while history and exam will no longer directly contribute to selecting the E/M code, the ED E/M codes stipulate that there should be a medically appropriate history and/or physical examination.

There are modifications to the criteria for determining the level of MDM, as explained in FAQ #5. Interestingly, the final diagnosis will not be the sole determining factor for an E/M code. Presenting symptoms likely to represent a highly morbid condition may require an extensive evaluation. These extensive diagnostic and/or therapeutic interventions to identify or rule out a highly morbid condition will determine MDM even when the ultimate diagnosis is not highly morbid. This helps reinforce the concept of the prudent layperson standard.

FAQ #6 lays out a grid to use to measure MDM and understand what code to bill. MDM is broken out into three categories: 1) Number and Complexity of Problems Addressed; 2) Amount and/or Complexity of Data to be Reviewed and Analyzed; and 3) Risk of Complications / Morbidity / Mortality of Patient Management. Based on those three MDM factors, you can pick a level 1 (no MDM), level 2 (straight forward MDM), level 3 (low MDM), level 4 (moderate MDM), or level 5 (high MDM) service.
Most of the remaining FAQs explain these three categories in detail and include numerous clinical scenarios that will help you determine the appropriate MDM level within each category.
Number And Complexity of Problems Addressed: The most significant change here is that there is no longer a major distinction made for additional workup planned and no longer points for a new problem to the examiner.
Amount and/or Complexity of Data to be Reviewed and Analyzed: This component has the most changes in clarifications including scoring for ordering or reviewing each unique test.
Risk of Complications and/or Morbidity or Mortality of Patient Management: This is still based on the previous "table of risk" with the highest element of risk prevailing for the level assigned. It is important to note that social risk factors, such as homelessness and food insecurity, count as "moderate risk." This is the first time that social risk factors have impacted the level of service that you as emergency physicians will bill.

Finally, another major change, highlighted in FAQ #36, is that you can get MDM credit for the decision making process regarding whether to initiate or forego further testing, treatment, and/or hospitalization/escalation. In other words, even if you ultimately decide not to order a test, treatment, or management option, the consideration of such an action or service can contribute to the complexity of the medical decision.

Written by: Jeffrey Davis, Director of Regulatory and External Affairs at ACEP

ICEP Calendar *of* Events 2023

(Subject to change)

February 16, 2023
Emergency Medicine Update
Peoria, IL

April 17 + 18, 2023
Virtual Oral Board
Zoom

May 9, 2023
EM4Life – 2022 LLSA Article Review Course
Downers Grove, IL

May 25, 2023
Spring Symposium & Annual Business Meeting
Chicago, IL

August 24, 2023
Resident Career Day & Recruitment Event
Chicago, IL

August 28 + 29, 2023
Virtual Oral Board
Zoom

November 13 + 14, 2023
Virtual Oral Board
Zoom

See the latest at ICEP.org and follow on Facebook and Twitter!

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