Vol. XLII No. 3

Find us on: facebook

Follow us on twitter

May/June 2022

In This Issue

2 From the President

Gregory Gafni-Pappas, DO, FACEP

"When I was a child, I could often be heard saying, "That's not fair." Ever since then, I have been on a mission to correct inequity and injustice. And what I've found is, it's not that easy. Unfortunately, life is simply not fair, owing to a whole host of uncontrollable variables. But that's not to say we shouldn't try to flip the status quo and do what's right. For me, this is one of the largest reasons I became involved in MCEP. It was an opportunity to engage in the issues within our specialty and to have a chance to make a difference in emergency medicine and, on a grander scale, the entire house of medicine."

3 From the Editor

Sara Chakel, MD, FACEP

"Balance is something that we talk about all the time in the context of emergency medicine.

At work, we balance the needs of multiple patients with completing documentation, taking phone calls or reading messages, ordering and interpreting diagnostic results, and caring for the next emergency rolling in through the front or back door. We also balance our clinical duties with anything that we are working on in an administrative capacity for our groups as well as teaching duties or research projects for those who work in academia or with residents and students. Many of us also work to balance our clinical lives and emergency medicine group lives with our volunteer lives working for EM organizations such as MCEP, ACEP, and others. Some of us also donate our time and expertise providing medical care to underserved populations around the world."

4 Reimbursement Corner

Don H. Powell, DO, FACEP

"This month, we dive a little deeper in preparation for the likely coding changes in the upcoming 2023 final rule. We will also highlight the degree of complexity in the coding realm that many clinicians aren't aware of. We will show some of these complexities that are required for maximum reimbursement and the reasons behind some of the seemingly unimportant requests that providers receive from their revenue cycle management partners."

7 MCEP Resident Case Report

Rachel Trumpy, MD; Lindsay Nausin, DO; and Don Custodio, DO of Western Michigan University Homer Stryker MD School of Medicine in Kalamazoo, MI.

Submissions to the July/August 2022 Newsletter should be received by the Chapter office no later than July 20, 2022.

Contents

3 Calendar of Events

9 EMRAM President Column

PRESIDENCY YEAR REFLECTIONS

When I was a child, I could often be heard saying, "That's not fair." Ever since then, I have been on a mission to correct inequity and injustice. And what I've found is, it's not that easy. Unfortunately, life is simply not fair, owing to a whole host of uncontrollable variables. But that's not to say we shouldn't try to flip the status quo and do what's right. For me, this is one of the largest reasons I became involved in MCEP. It was an opportunity to engage in the issues within our specialty and to have a chance to make a difference in emergency medicine and, on a grander scale, the entire house of medicine.

In my time on the board and as president, I have seen legislators who make unfair laws, regulators who make unfair rules, insurance companies who take part in unfair practices (not to mention unfair reimbursement while making billions in profit), and a virus that created an unfair pandemic. Through it all, MCEP has been a constant in my life, defending our practices and our patients. My involvement as a member and on the board has given me a voice.

This past year alone, we have seen several assaults to our specialty. Insurance companies can now essentially game the system by forcing physician groups out-of-network, allowing them to reimburse less because of poor legislation passed in our state. And insurance company denials continue to be a problem for EM groups in Michigan. Increased scope-of-practice is on the rise with the recent passage of a bill allowing independent practice for CRNAs, as well as other legislation increasing independence for NPs in rural areas by allowing them to prescribe controlled substances without physician oversight. This could be the beginning of further scope creep bills that more directly affect EM. Unlock Michigan 2 (a petition put together by Michigan citizens) is attempting to undo the ability of the Michigan Department of Health and Human Services to institute emergency restrictions during a public health crisis. Do we want legislators dictating public health measures, or experts in public health? Legislators are working to create mandatory lead poisoning CME for all physicians in Michigan without evidence that this would improve detection or outcomes. This comes as legislators have already created multiple other CME requirements without evidence of benefit. And our Violence in the ED bill, while increasing penalties for violence from ED visitors and requiring appropriate waiting room signage, falls short of increasing penalties for patients due to push back from legislators.

You win some and you lose some, and we have certainly had some major wins in the past 10 years. But it seems we have had several losses in the last couple of years, even while doing everything within our power to avoid these outcomes. This is not only happening within our state but on a national level as well. The question is whether it is time to go on the offensive. Do we need to change our mindset from a wait-and-see defensive approach to a proactive get-on-top-of-the-issue strategy? This may be easier said than done but needs to be on the forefront of discussions as we think about strategy after the coming mid-term elections and beyond.

Should we introduce legislation proactively? Should we create more meetings with insurance companies? Do we consider lawsuits when egregious practices are not reconciled by discussions and negotiation? Do we make our coalitions with other organizations more robust and create more actionable plans for interspecialty issues? These and other forward-looking strategies must all be on the table for discussion. While it can feel uncomfortable to be on the offense, it is more uncomfortable to constantly defend ourselves. We need to anticipate and strike before others can mobilize. This won't be easy, but we are emergency physicians. If anyone can do it, we can. Whether we win or lose, we must speak our truth to ensure a bright future for our specialty.

Gregory Gafni-Pappas, DO, FACEP

I am proud to be an emergency physician and to be a member of the Michigan College of Emergency Physicians. It has been one of the biggest honors of my life to lead this organization. As my presidency comes to an end, I think back on this year, a year of significant transition and contemplation, but also a year of advancement and shifting of internal culture to transparency, improved processes, innovation, and future-oriented thinking. For my incoming report as president, I put forward an agenda to implement, innovate, and recharge. The foundation has been set, and we are beginning to make strides. But I ask the membership, the Board, and the incoming executive leadership to continue a forward-thinking aggressive strategy based on the continual refinement of our mission and values, in order to propel MCEP not only to version 2.0, but to 3.0 and beyond. Thank you to all the amazing MCEP board members and incredible staff for supporting me over the past year, and thank you to all the members for entrusting me to serve you as your president. §

www.mcep.org

BALANCE

Sara Chakel, MD, FACEP

Balance is something that we talk about all the time in the context of emergency medicine.

At work, we balance the needs of multiple patients with completing documentation, taking phone calls or reading messages, ordering and interpreting diagnostic results, and caring for the next emergency rolling in through the front or back door. We also balance our clinical duties with anything that we are working on in an administrative capacity for our groups as well as teaching duties or research projects for those who work in academia or with residents and students. Many of us also work to balance our clinical lives and emergency medicine group lives with our volunteer lives working for EM organizations such as MCEP, ACEP, and others. Some of us also donate our time and expertise providing medical care to underserved populations around the world.

At home, we talk about balancing multiple responsibilities between family, personal well-being, financial wellness, side projects, and home upkeep alongside our clinical responsibilities. This might look like maintaining a strong relationship with a partner, supporting children in their sporting endeavors, helping family members negotiate the healthcare system, focusing on a hobby or fitness or sleep, or planning the next big vacation or other adventure.

Working in emergency medicine lends itself as a blessing and a curse towards achieving balance in all aspects of life. From our earliest experiences in the emergency department, we are taught how to balance competing priorities, how to juggle at least one more ball when our hands are already full, and how to do this well. We see this time and again when our colleagues around the country and the world discuss how they responded to unexpected and sudden mass casualty incidents, working as the leaders to coordinate complex systems in times of extreme crisis.

Yet, in learning to balance, we are asked to take on evermore responsibility. This can manifest professionally as more patients per hour, more responsibilities in the hospital, more academic duties, or more involvement in state or national organizations. And this can take away balance from our other life, the one that we live when we are not physicians practicing emergency medicine.

As I move through my career and my life, I have swung like a pendulum. As many know, I was, at one time, very successful with my goal to "live and work where people go on vacation." I have also done locums tenens work in which my only responsibility was to work my rostered hours and enjoy my free time. For the past few years, I have been very involved in many things I am passionate about, including teaching and MCEP and advocacy. I think there is a season for all levels of involvement, and wellness and balance can be found no matter how involved (or not) someone chooses to be.

Going forward, we as emergency physicians need to continue to strive for balance. We need to be able to say enough-is-enough when our limits are reached. We need to consider whether we are living to work, or working to live, or some middle-ground between these two extremes. What brings happiness and fulfillment will look different to each of us, as we are all unique individuals.

We seem to be entering an ever-more turbulent time in medicine and society. The past few years have brought enormous political upheaval, a decreasing emphasis and trust in science in day-to-day life, a never-ending pandemic, and economic/societal uncertainty. We continue to deal with the challenges of stagnant/declining reimbursement, staffing challenges in our departments and hospitals, and patients who are struggling to get needed healthcare in the outpatient world, outside of our emergency departments and hospitals.

As emergency physicians, we are leaders in times of crisis. We need to be at the forefront of these challenges. Yet, at the same time, we need to remember balance. As we enter the peak of the summer season, let's all take time to remember our "why." This is different for each of us. Think about why you do what you do. What brings you joy? What nourishes your spirit? Is there anything you can let go? I hope to see many of you at one of my "well" events next month, the Michigan Emergency Medicine Assembly, and in the interim, I would advise you all to strive for balance. §

MCEP Calendar of Events

July 31- August 3, 2022
Michigan Emergency Medicine Assembly
Grand Hotel
Mackinac Island, Michigan

August 1, 2022
Board of Directors
Grand Hotel
Mackinac Island, Michigan

August 18, 2022
EM Career Planning: Life After Residency
Somerset Inn
Troy, Michigan

September 7, 2022
Board of Directors
Chapter Office
Lansing, Michigan

September 12-13, 2022
Observation Medicine Conference
Doubletree by Hilton
Downtown Nashville
Nashville, Tennessee

September 20, 2022
MCEP Councilor Meeting
Chapter Office
Lansing, Michigan

September 29-30, 2022
ACEP Council Meeting
San Francisco, California

October 1-4, 2022
ACEP Scientific Assembly
San Francisco, California

November 15, 2022
$traight Talk Reimbursement Course
Somerset Inn
Troy, Michigan

December 7, 2022
Board of Directors
Chapter Office
Lansing, Michigan

CORRELATION OF HYPERTENSION, HEART FAILURE, AND KIDNEY DISEASE IN DOCUMENTATION PRACTICES

Don H. Powell, DO, FACEP

This month, we dive a little deeper in preparation for the likely coding changes in the upcoming 2023 final rule. We will also highlight the degree of complexity in the coding realm that many clinicians aren't aware of. We will show some of these complexities that are required for maximum reimbursement and the reasons behind some of the seemingly unimportant requests that providers receive from their revenue cycle management partners.

Reimbursement for Emergency Medicine will continue to transition from Fee-For-Service to Value-Based Reimbursement (VBR). Cost is an important component of VBR programs. Applying Hierarchical Condition Category (HCC) codes to the ED encounter helps to communicate patient complexity to payors. This complexity is then used to help predict health care resource utilization and to risk adjust quality and cost metrics used in VBR programs (e.g., MIPS and other value-based risk contracts).

Per ICD-10 coding guidelines, there is a casual or assumed relationship between hypertension, chronic kidney disease, and cardiac involvement. This is true regardless of the provider specifying if they are related in the chart, unless it is clearly stated they are not related. This is a result of the ICD-10 coding definition word "with" when located in the alphabetic index under the main term or subterm. When the word "with" is used in the index, it should be interpreted to mean "associated with" or "due to."

With this assumed relationship and coding notes in the tabular section, there are many different ICD-10 codes that should be reported. These diagnosis codes contain many specific options. They are further sub-divided into 3 code categories of I11- Hypertensive Heart Disease, I12- Hypertensive Chronic Kidney Disease, and I13- Hypertensive Heart and Chronic Kidney Disease.

In addition to the different coding instructions for I11-, I12-, and I13-, at the beginning of the Hypertensive Diseases section I10-I16, there are also instructions to use additional codes to identify the use of tobacco products, history of tobacco dependence, or exposure to tobacco smoke. This instruction pertains to all codes in that section, in addition to all the prior coding notes.

I11- HYPERTENSIVE HEART DISEASE

This includes cardiac conditions in code categories I50- Heart Failure and I51.4-I51.9 from the section of complications and ill-defined descriptions of heart disease. I11.0 Hypertensive Heart Disease has a coding note to also identify the type of heart failure from section I50-. Codes I51.4-I51.9 would not be listed separately.

To code to the highest specificity, coders would also need to know the specific type of heart failure. Examples include systolic, diastolic, combined, acute, chronic, acute-on-chronic, etc.

Coding example: Patient has acute-on-chronic combined systolic and diastolic heart failure, hypertension, and a history of tobacco use. This would be coded as:

- I11.0 Hypertensive Heart Disease with Heart Failure
- I50.43 Acute-on-Chronic Combined Systolic and Diastolic Heart Failure
- Z72.0 Tobacco Use

I12- HYPERTENSIVE CHRONIC KIDNEY DISEASE

This includes Chronic Kidney Disease in N18- and Unspecified Contracted Kidney N26-.

N18.1-N18.9 would be coded in addition to I12-. Codes N26- would not be listed separately as there is an exclusion note under N26- for I12-.

To code to the highest specificity, coders would also need to know the specific stage of chronic kidney disease or that they have end stage renal disease and whether the patient is receiving dialysis. If the patient has stage 5 chronic kidney disease but receives dialysis, this is coded as end stage renal disease. An additional code for the dialysis would also be used when pertinent, Z99.2.

Coding example: Patient has hypertension and stage 3b chronic kidney disease. This would be coded as:

- I12.9 Hypertensive Chronic Kidney Disease with Stage 1 through Stage 4 Chronic Kidney Disease
- N18.32 Chronic Kidney Disease Stage 3b

I13- HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE

The tabular section specifies this to include any condition in I11- with any condition in I12-. The coding notes for the separate sections above would be combined and used for this category as well.

Coding example: Patient has hypertension, chronic systolic heart failure, stage 5 chronic kidney disease, receives dialysis, and has a history of tobacco dependence. This would be coded as:

- I13.2 Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease or End Stage Renal Disease
- I50.22 Chronic Systolic Heart Failure
- N18.6 End Stage Renal Disease to represent the stage 5 chronic kidney disease since the patient is on dialysis
- Z99.2 Dependence on Renal Dialysis
- Z87.891 Personal History of Nicotine Dependence

TAKE HOME NOTES:

1. Be as specific as possible in final diagnosis regarding:
   - Heart failure: Acute vs chronic vs acute-on-chronic and systolic vs diastolic vs combined
   - Renal Disease: List stage if known
   - Tobacco Use
2. Be prepared for much more required specificity and details in the medical decision making (MDM) areas of documentation in the upcoming months pending the 2023 rules. §

Don H. Powell, DO, FACEP
President- Medical Management Specialists

Amy Westerhuis, CPC, CEDC, CDEO
Medical Coding Manager- Medical Management Specialists

HEALTHCARE PROFESSIONALS

treated fairly

With the recent acquisition of NORCAL Group, ProAssurance is now the nation's third largest medical professional insurance carrier with claims and risk management expertise in every major healthcare region.

Meet the new best-in-class, where the principle of fair treatment guides every action we take in defense of our medical professionals.

PROASSURANCE
NORCAL GROUP

Healthcare Professional Liability Insurance & Risk Management Services

Proudly endorsed by

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

For information regarding the NORCAL Group acquisition ›››

ProAssurance.com

ITP PRESENTING AS HEMORRHAGIC BULLAE OF THE ORAL MUCOSA

Rachel Trumpy, MD, Lindsay Nausin, DO, Don Custodio, DO
Western Michigan University Homer Stryker M.D. School of Medicine

INTRODUCTION

Immune thrombocytopenia (ITP), formally known as idiopathic or immune thrombocytopenic purpura, is an acquired immune mediated disease of exclusion.[1] Findings on presentation can vary widely from normal exam to intracranial hemorrhage. Many patients are asymptomatic with thrombocytopenia found incidentally on routine laboratory studies.[3] Oral blood blisters are more typical of severe thrombocytopenia.[2]

CASE REPORT

A 35-year-old female with a history of GERD, chronic nausea, and joint pain presented to the emergency department for one day of blood blisters in her mouth. She initially felt a large blister on her right buccal mucosa which she attributed to biting her cheek earlier in the week. Over the course of several hours, she noticed two new black lesions on her tongue. The following morning, on the day of presentation, she had multiple new blood blisters on the bilateral buccal mucosa and additional lesions on her tongue. These lesions were painful and easily bled when scraped. While in the exam room of the ED, she also noticed the appearance of a scattered red rash on her arm.

Upon questioning, the patient reported that she had nicked herself shaving the day before, and it took much longer than normal to stop the bleeding. She denied any heavy periods, although she did have an IUD. No bleeding gums, hematuria, or easy bruising was reported. Review of symptoms was otherwise negative.

She denied any recent illnesses such as an upper respiratory infection. Her only change in medication was the addition of Adderall a couple of months prior, but she reported not taking the medication recently. She denied taking any aspirin, other antiplatelet, or anticoagulant medications.

Examination revealed a well-appearing young female in no distress. Multiple black lesions were noted on the tongue as well as numerous hemorrhagic bullae and petechiae on bilateral buccal mucosa, soft palate, and hard palate with no obvious bleeding of the gums or bullae. A few scattered petechiae were seen on the left forearm as well as a larger purpuric lesion on her forehead. The remainder of her exam was normal.

The patient's vital signs were stable. Lab work-up was overall unremarkable except for marked thrombocytopenia with a platelet count of 5 x 10^9/L. Hematology was consulted and agreed with starting the patient on high dose steroids and intravenous immunoglobulin (IVIG). Given the severity of thrombocytopenia, she was also given a platelet transfusion. The patient was admitted to the hospital.

Further work-up in hospital was not consistent with disseminated intravascular coagulation (DIC) or thrombotic thrombocytopenic purpura (TTP), and review of medication list did not reveal any medications associated with drug induced thrombocytopenia. Ultrasound revealed no hepatosplenomegaly, and bone marrow was without evidence of suppression.

While in the hospital, the patient had persistent thrombocytopenia with platelets <10 x 10^9/L , requiring an additional transfusion of platelets and two additional doses of IVIG. Given the lack of other diagnoses with otherwise unremarkable work-up, the patient was ultimately diagnosed with ITP. After several days of treatment, the patient's platelet counts improved to 40 x 10^9/L, and she was discharged home with outpatient hematology follow-up and slow taper of high dose of steroids over two weeks.

DISCUSSION

Immune thrombocytopenia, ITP, is an immune mediated process caused by the destruction of platelets by autoantibodies. The incidence of immune thrombocytopenia in adults is 1.6-3.9/100,000/year.[2] Females have an increased prevalence compared to men in early decades of life, however, with ages greater than 60 years, the difference in prevalence is less significant.[2-4] The hallmark of the disease is transient or persistent decrease in platelets (<100 x 10^9/L) with increased risk of bleeding.[1] Findings on presentation can vary widely from normal exam to intracranial hemorrhage.

As in the case above, treatment for primary ITP is focused around immunomodulators. Rather than aiming for a normal platelet level, the ultimate goal of treatment is a high enough platelet count to prevent fatal bleeding, usually >30 x 10^9/L.[1] First line management includes oral prednisone 1 mg/kg/day for 2-6 weeks including taper.[4,5] IVIG can be used to supplement steroid treatment, especially when a more immediate response is needed.[4,7] Splenectomy has long been a viable second line treatment option and often has some of the best long term success rates; however, this is utilized in less than 25% of cases.[4,5,7] Transfusion of platelets may also be needed to treat or prevent major bleeding or prepare for an invasive procedure.[6,7] While there is no set level that should prompt transfusion, <30 x 10^9/L is often used unless undergoing a procedure at which time <50 x 10^9/L is a common cut off.[4-7]

Immune thrombocytopenia has diverse presentations ranging from an asymptomatic incidental finding to fatal intracranial or GI bleeding. In our case, the patient presented with bullae and petechiae of the oral mucosa. Most patients presenting with bleeding have a severe thrombocytopenia with a platelet count less than 30 x 10^9/L as seen in our case above who had a platelet count of 5 x 10^9/L. §

REFERENCES

1. Rodeghiero F, Stasi R, Gernsheimer T, et al. Standardization of terminology, definitions and outcome criteria in immune thrombocytopenic purpura of adults and children: report from an international working group. Blood. 2009;113(11): 2386-2393.
2. Beutler E, Lichtman M, Coller B, et al, eds. Williams Hematology. 6th ed. New York, NY: McGraw-Hill Book Co; 2018.
3. Frederiksen H, Schmidt K. The incidence of idiopathic thrombocytopenic purpura in adults increases with age. Blood. 1999;94:909-913.

4. Pruemer J. Epidemiology, pathophysiology, and initial management of chronic immune thrombocytopenic purpura. Am J Health Syst Pharm 2009;359(Suppl 2):S4-10. doi:10. 2146/ajhp080490 pmid:19139489.

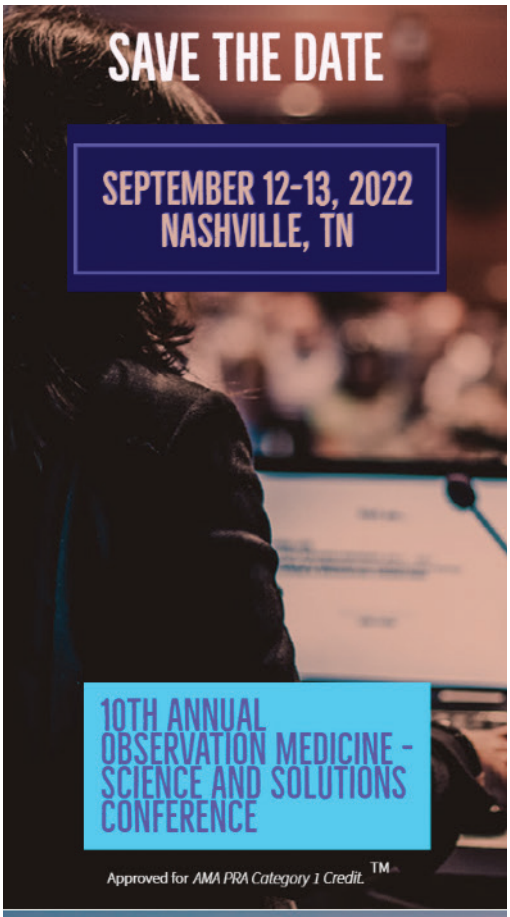
5. Lambert MP, Gernsheimer TB. Clinical updates in adult immune thrombocytopenia. Blood 2017;359:2829-35. doi:10.1182/blood-2017-03-754119 pmid:28416506

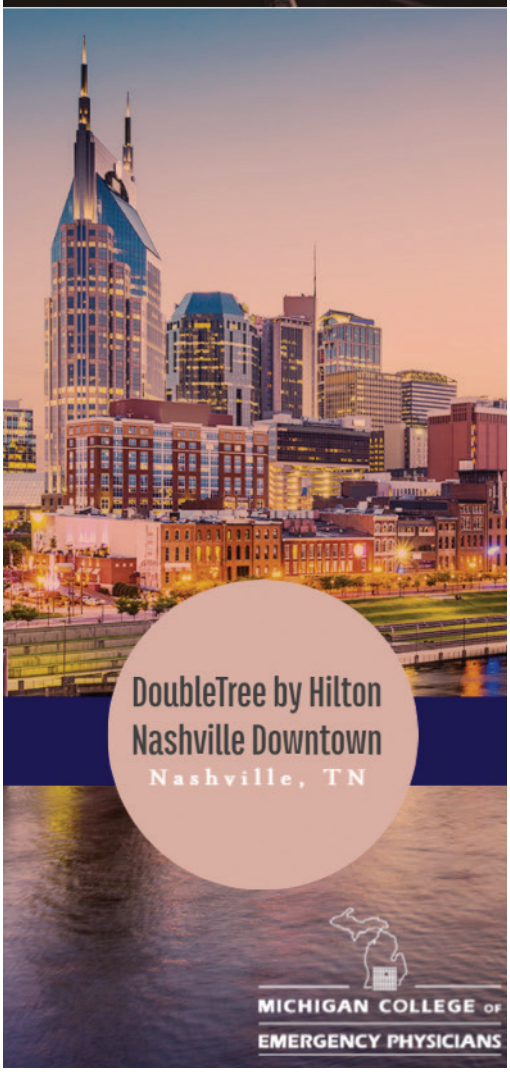
6. Squires JE. Indications for platelet transfusion in patients with thrombocytopenia. *Blood Transfus*. 2015;13(2):221-226. doi:10.2450/2014.0105-14

7. Kado R, McCune WJ. . Treatment of primary and secondary immune thrombocytopenia. Current Opinion in Rheumatology. 2019;31(3):213–222. doi: 10.1097/BOR.0000000000000599.

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

Michigan Emergency Medicine News & Views is the official publication of the Michigan College of Emergency Physicians. Deadline for publication of all letters/articles is the 5th of the month prior. All correspondence should be addressed to MCEP News & Views, 6647 West St. Joseph Hwy., Lansing, MI 48917. Telephone (517) 327-5700, FAX (517) 327-7530, www.mcep.org. Opinions expressed within this newsletter do not necessarily reflect the College's point of view. While News & Views believes that the ads it accepts originate from reputable sources, it takes no responsibility for the consequences resulting from, or the responses generated by, any commercial or classified advertisement.





EMRAM PRESIDENT COLUMN

Dear MCEP and EMRAM,

I want to take this time to thank you and to reflect upon the honor I have had of serving you as your elected EMRAM President this year and as your Vice President last year.

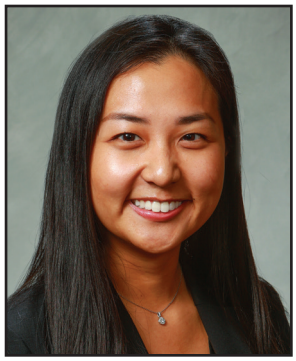
With your support, EMRAM has achieved and checked off a few new items in its agenda:

1. We have increased our social media presence on Instagram, Twitter, and Facebook, with more residency involvement across the state to better represent you. We could see a difference in officer elections this year, with the most candidates that we have received in the last three years.
2. We have established a resident representative from each of twenty-seven programs across Michigan.
3. We have focused upon advocacy by listening to you and by speaking up for current and future EM residents – their education, work force, and future – e.g., we addressed the MCEP Board of Directors regarding MSUCOM's new PA school joining the DO students in classes.
4. We have built a bridge between medical students and EM resident physicians with our new Mentor-Mentee program.
5. We have started brunch with EMRAM, an up-and-coming program to host a residency every quarter.

Of course, we have thoroughly enjoyed already established programs, including the Michigan Emergency Medicine Assembly in Traverse City, the Life After Residency conference, SIMWARS, MCEP at ACEP, the MCEP Winter Symposium at Boyne, the In-Training Exam Review, and Mock Oral Boards, to list a few.

I am excited to see what is ahead for EMRAM and what the new Board will bring for us. Though I am moving away to start my fellowship at the Hospital of the University of Pennsylvania, you will always be my home. Thank you again for this tremendous honor, opportunity, and role to represent you, to speak up for you, and to work alongside you. You have given me the experience of learning and growing into the physician and individual I am today as I move forward to the next chapter.

Sincerely,
Suzie Park, DO



Suzie Park, DO