Where Did the Bullets Go?

The new E/M system is based on 3 key factors.

BY MICHAEL J. KING, DPM

So you finally got the hang of counting bullets in your E&M services and now they have gone away? Why do they keep changing this on me? Well, believe it or not, the bullet counting started in 1995, 25 years ago. Sounds crazy doesn't it? In 1997, they revised those bullets again, making it easier for DPMs to reach a more realistic level of coding with access to more bullets. Then, the notices started coming about using "too many level-3 codes" from the carriers causing new levels of concern and consternation. Fear not DPMs, this change is for the better for all of medicine and especially for the DPM.

Do you remember about two years ago, CMS wanted to institute G codes ONLY for podiatrists? Thankfully, APMA and its sister medical organizations were able to stop this from occurring. That was the beginning of this process—changing the paradigm of how E&M codes were to be documented. As the regulatory burdens increased, so did the outcries for making the physician's decision-making key, in how notes are valued (at what level we can code to) and to eliminate the fluff necessary in a note to appease an auditor sitting at the MACs.

Of course, the complexity and severity of these diagnoses increase, as do the coding levels but they are now easily obtainable by the DPM, even occasionally up to a level-5 code! Note: This is in no way endorsing the billing of level-5 or saying that we can get there easily or often, but this change makes it a possibility for those of us treating very complex or limb threatening conditions.

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The new way to document E&M services is based on three key factors: **First, the number and complexity of problems encountered.** Now the physician can use the diagnosis(es) as one of the parameters around which to document, instead of just adding details about it.

Second, the amount and/or the complexity of the data to be reviewed and analyzed. Now, we can be credited with our review, documentation, and discussion of external studies, both radiologic and

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pathologic. We can be given credit for our discussion with "independent historians" such as parents of a child patient, caregivers, or even an outside physician. We get one bite at this apple; we cannot take credit on every visit for reviewing the same data.

Third, the risk of complications and/or morbidity or mortality of the patient. We, the physicians, will be tasked with determining the risk to the patient of their condition, their treatment, their lack or failure of therapies, and the like. Folks, all the above is known as medical decision-making!

This is finally relying upon the physician to be the arbiter of the risks to a patient and the professional decisions necessary to help patients stay well. It is no longer about just one bullet point from column A and two bullet points from column B and so on. Yes, there are still parameters to be met, but they are about our ability to recognize disease, manage it, and discuss disease management with our patients and their providers or families.

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There is one variation to this theme—time. Historically, DPMs have not relied on time for determining the code levels we use. This new system allows for that and considers all physician time, not staff time, but physician working time and gives credit for that. We even get credit for the time it takes us to do our notes!

I encourage you to look up the AMA MDM grid online and keep a copy nearby when documenting your visits. The AMA did a bang-up job on this grid and can be a great resource in guiding you to better coding, better reimbursement, and less risk of audit. **PM**

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