Medicare Corner
Fall 2016
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Each year at this time for more than twenty years I've been going to the CAC (Contractor Advisory Committee) meeting and more recently to the CAC-PIAC (Private Insurance Advisory Committee) meeting held by APMA. For me it's the best meeting APMA puts on each year and this year was no different.

Accompanied by Leslie Campbell, DPM and Don Blum, DPM, we attended the meeting in Baltimore, Maryland. We heard a combination of Medicare information that I will report on and private insurance that Dr. Campbell will report on. Part of what we hear was a lot of new information about MACRA (the Medicare Access and CHIP Reauthorization Act of 2015).

MACRA in addition to sun setting the PQRS program, the value-based payment modifier, the sustained growth rate formula, and the electronic health record program (which has been referred to as the meaningful use program) brings into being the MIPS (Merit Based Incentive Program) and the APM (Alternative Payment Model). As I reported last year, MIPS can and will cause adjustments to the Medicare fee schedule ranging from plus or minus 4% in 2019 to plus or minus 9% in 2022.

Kate Goodrich, MD, MHS, Director, Center for Clinical Standards & Quality at the Centers for Medicare & Medicaid Services reported to us on these programs. The MIPS program starts January 1, 2017. The data reported in 2017 will determine what your Medicare payments in 2019 will be: anywhere from a -4% to a +4% of the Medicare fee.

However if you have less than 100 Medicare Fee-for Service patient's and/or less than $30,000 in approved Medicare charges you are considered a low volume provider and will not have to participate in either MIPS or the APM. Also excluded from MIPS in their first year are newly enrolled providers and those providers significantly participating in Advanced APMs (which at least for 2017 will probably not podiatrists).

From a pure Medicare standpoint, MACRA authorizes the replacement of the patient's social security number and suffix letter with a random alphanumeric system by 2019. You will need to make sure your accounts receivable program will be able to accept this new numbering system.

In 2017 you can pick your own pace as you have four ways to participate. You can: (a) choose to test and submit a minimum amount of 2017 data to Medicare. That amounts to one measure. Since 62% of physicians currently participate in PQRS that should not be too difficult. Next (b) you can do partial participation by submitting 90-days worth of data. This should earn you a neutral (0% change) or small positive payment fee adjustment. (c) Full participation might be able to get you a moderate positive payment adjustment in 2019 based on these 2017 data elements. Last (d) you could participate in an APM, but again that will be hard to do for podiatrists in 2017.

In MIPS Performance Category the cost factor is weighted at 0% of final score in 2017. Cost will have an increased weighting over the next several years as cost is part of the law. Scoring will be done based on costs within each field and is risk adjusted based on the patient's comorbidities.

The website for the quality payment program is: qpp.cms.gov.

Next Marjorie Kanof, MD, MPH from Health Policy Alternatives, an APMA consulting firm spoke on these same topics. She prefaced her remarks by talking about the Medicare Fee for Service (FFS) Conversion Factor (CF) set by the Secretary of the Department of Health and Human Services. For the period July through December 2015 the update was 0.5% with a CF of $35.9335. In 2016 the annual update was 0.5%; in 2017 through 2019 the annual update will be 0.5%; in 2020 through 2025 there will not be any annual update; and in 2026 and beyond there will be two CF. Those qualifying APM participants will have an annual update of 0.75% while all other health care providers will have an annual update of 0.25%. So the CF for 2016 was $35.8043. The CF for 2017 will be $35.8887. She felt there should be no impact in podiatry for these two years.

Again MIPS will consolidate EHR, PQRS, and VM (value modifiers) into one program. MIPS will have four Performance Categories: Quality; Cost (Resource Use); Improvement Activities (Clinical Practice Improvement Activities); and Advancing Care Information (Meaningful Use of Electronic Health Records). The scoring performance will be based on thresholds set at mean or medium of prior period to develop a final score and adjust those scores to ensure budget neutrality. Since this program is generally budget neutral there has been a cap of the maximum reduction of -4% to +9% over 4 years. However exceptional performance will have an adjustment for FYs 2019 – 2024 of $500 million per year in a separate funding pool.

CMS it seems is still intent on trying to eliminate the global periods for surgery. Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, and Ohio will be required to file 99024 for their post operative visits so CMS can track them. If Texas podiatrists wish to do so, you can voluntarily submit this code for post operative care in a global period to Medicare so it can be tracked.

In addition, CMS will review: biopsy of finger or toenail (11755); strapping of ankle/and or foot (29540); strapping of toes (29550); and removal of nail plate (11730) as possible misvalued codes in their global scheme.

Next and very important to those who still use film for their X-rays, CMS has imposed a new modifier: **–FX**. Since most podiatrists bill the full (technical and professional) component of X-rays, the **–FX** modifier will be appended to all your X-ray studies. If you only provide the professional component for your radiographs, but do not take the films then you do not have to append the **–FX** modifier along with the –26 modifier. The use of this modifier starts January 1, 2017 and will cause a 20% reduction in the technical payment part of the whole payment component for X-ray studies.

CMS has rolled the MPIS and APMs into a program call the Quality Payment Program (QPP). The final rule was published in the Federal Register on November 4, 2017 (CMS posted the final

rule on October 14, 2016). Implementation will begin January 1, 2017 (with 2017 performance period for payment adjustment being reflected in 2019).

MIPS has 4 performance categories: Quality; Cost (Resource Use): Clinical Practice Improvement Activities (CPIA); and Advancing Care Information (ACI). The final performance score will be based on all these performance categories will be calculated and a payment adjustment will be based on the MIPS final performance score as compared to a performance threshold set at mean or medium of prior performance. The MIPS final performance score will be equal to the performance threshold and receive a neutral MIPS payment adjustment as this program is generally budget neutral.

Performance Category	**2019**	**2020**	**2021 and beyond**
Quality	60%	50%	30%
Cost (Resource Use)	0	10%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information (Meaningful Use of EHR)	25%	25%	25%
Maximum MIPS Reduction	4%	5%	7% for 2021 9% for 2022 …

- If Secretary determines an eligible provider does not have enough measures, then the weight distribution can change.
- If EHR adoption reaches 75%, the meaningful use weight can decrease to 15% and be redistributed

Quality Category (Replaces the Physician Quality Reporting System (PQRS):

- Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.
- Groups using the web interface**:** Report 15 quality measures for a full year.

Improvement Activities (a new category:

- Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.
- Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.
- Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: Automatically earn full credit.

Advancing Care Information (Replaces the Medicare EHR Incentive Program also known as Meaningful Use):

- Fulfill the required measures for a minimum of 90 days:
  - Security Risk Analysis
  - e-Prescribing
  - Provide Patient Access
  - Send Summary of Care
  - Request/Accept Summary of Care
- Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

OR

- You may not need to submit Advancing Care Information if these measures do not apply to you.

Cost (Replaces Value-Based Modifier):

- No data submission required. Calculated from adjudicated claims.
- Total Per Capita Cost Measure
- Medicare Spending Per Beneficiary Measure
- Episode Measures

You will have four options for participating in 2017. I will repeat this later in this report. (1) You can test the program by submitting one measure and thus avoid a negative payment adjustment. (2) You can participate for part of the year by submitting data during a 90-day continuous performance period. This could qualify you for a small positive payment adjustment. (3) Your can participate for the full year. (4) Or you can participate in an Advanced APM. If you don't send in any 2017 data you receive a negative 4% payment adjustment. As noted the first payment adjustments based on 2017 performance will go into effect January 1, 2019.

Eligible clinicians can submit either as individuals or as a group. A group is defined as a single taxpayer identification number (TIN) with two or more eligible clinicians that includes at least one MIPS eligible clinician as identified by their NPI and have assigned their Medicare billing rights to the TIN. Also as previously noted new Medicare-enrolled eligible clinicians who have enrolled during the performance year and/or who were not previously part of a group or billing under a different TIN will not have to participate in MIPS in 2017. In addition clinicians (individual and groups) below the low-volume threshold defined as equal to or less than $30,000 in Part B allowed charges or who provide care for 100 or less Part B beneficiaries will not be subject to the MIPS program.

CMS expects to distribute about $199 M in payment adjustments in 2019 on a budget neutral basis. There will also be an additional $500 M for exceptional performance. Finally approximately 40% of MIPS eligible clinicians will be excluded. This amounts to approximately 22% to 27% of total Part B charges.

For another take on MIPS we had a lecture from Jeffrey Lehrman, DPM. He is a member of the APMA Coding Committee and a board member of the American Society of Podiatric Surgery and the American Academy of Podiatric Practice Management.

Eligible providers will receive either a positive or negative payment adjustment to the Medicare fee schedule based on their MIPS score. As noted payment reductions and bonuses will come two years after the reporting period. So the maximum negative adjustments in 2019 will be -4%

(based on 2017 reporting); in 2020 - 5% based on 2018 reporting; in 2021 -7% based on 2019 reporting; and in 2022 -9% based on 2020 reporting.
As we know in the first year of MIPS:

- Quality (replaces PQRS) 60%
    - Choose 6 measures instead of 9
- ACI (replaces MU) EHR use 25%
    - Emphasis on interoperability and information exchange
- Clinical Practice Improvement Activities 15%
    - Activities that focus on care coordination
    - Patient engagement
    - Patient safety
    - Over 90 options
- Cost - based on MC claims data, no reporting 0%

Of the Quality, the physician must choose essentially 6 PQRS measures of which it is believed that one must be an outcome measure. Some of those measures podiatrists should be picking from are:

1. Diabetes Foot Exam
2. Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurologic Exam
3. Diabetic Foot and Ankle Care, Ulcer Prevention – Examination of Footwear
4. Functional Status Change for Patients with Foot or Ankle Impairments (a process measure)
5. Documentation of Current Meds in the Medical Record (a process measure)
6. Fall Risk Screening
7. Falls: Plan of Care
8. Pneumococcal Vaccination Status for Older Adults
9. BMI Screening and Follow Up Plan
10. Influenza Immunization
11. Screening for High Blood Pressure and Follow Up
12. Tobacco Screening and Cessation Intervention

Under the Advancing Care Information (ACI) physicians only need to report on 5 measures and you get 50% credit just for reporting. The other 50% depends on your performance. There is no more clinical decision support rule and no more computerized physician order entry (CPOE). One of the goals of ACI is to make it easier for patients to access their health information.

The five ACI measures that podiatrist should report are:

1. Protect Patient Health Information (which must be a yes, no or zro for ACI)
2. Patient Electronic Access (numerator/denominator)
3. Send Summary of Care (numerator/denominator)
4. Electronic Prescribing (numerator/denominator)
5. Request / Accept Summary of Care (numerator/denominator)

These ACI measures will be 25% of MIPS scoring so you will get 25 MIPS points. A score of 100 or above on ACI will get you're the full 25 MIPS points. The base score (up to 50) plus the performance Score (up to 80) plus the bonus point (1) that can equal a maximum of 131 points.

A base score of 50 points will be given for just reporting numerators/denominators or yes/no for these 5 measures. But you can submit more than these five measures to get extra credit. The ACI is not all or nothing.

The nine ACI measures that can be reported are:

1. e-Prescribing
2. Health Information Exchange
3. Immunization Registry Reporting
4. Medication Reconciliation
5. Patient-Specific Education
6. Provide Patient Access
7. Secure Messaging
8. Security Risk Analysis
9. Specialized Registry Reporting
10. Syndromic Surveillance Reporting
11. View, Download, or Transmit (VDT)

The Clinical Practice Improvement (CPI) Activities will earn up to 15% of the MIPS in 2019. There is a listing of more than 90 options weighted as either "high" or "medium." You can choose either 2 high-weighted or 4 medium-weighted activities if you are in a group of more than 15 clinicians in order to get a maximum score. If you are in a group of 15 or fewer clinicians you can choose either 1 high-weighted or 2 medium-weighted activities to get a maximum score.

Some of the CPI activities are:

1. Registration in prescription drug monitoring program
2. Implement Fall Risk Assessment Program
3. Provide 24/7 access to clinician who has real-time access to patient's medical record
4. Assess patient experience of care through surveys, advisory councils and/or other mechanisms
5. Use decision support and standardized treatment protocols
6. Program to send reports back to referring clinician

In 2019 the Cost measure rates 0% and is calculated by claims review so there is no additional reporting. In future years you can get higher points for more efficient resource use and each cost measure will be worth up to 10 points.

So in MIPS you can "pick your own pace." The first option is to: Test the Quality Payment Program.

- Report one quality measure or one clinical practice activity or report the 5 ACI measures
- This will avoid negative adjustment
- But there will be no bonus

The second Option: Participate for part of the calendar year.

- You must report for a minimum of 90 days

- You must report more than one quality measure or more than one clinical practice improvement activity or more than 5 measures of ACI
- This will avoid a negative payment adjustment and possibly qualify for a small positive payment adjustment.

The third option: Full Participation

- 90 days to one year
- 6 Quality Measures
- CPI
    - Practice ≤ 15 employees - either 1 high-weighted or 2 medium-weighted activities
    - Practice ≥ 15 employees - either 2 high-weighted or 4 medium-weighted
- 5 ACI Measures

If you participate in an Advanced APM:

- Your are exempt from MIPS payment adjustments
- To have a successful participation you get a 5% bonus and no MIPS adjustment
- You have to receive certain amount of payments or see certain number of patients through APM

Understand that Advanced APMs are those programs in which clinicians accept risk for providing coordinated, high- quality care.

The next exciting lecture we heard was from Dyane Tower, DPM, MPH, MS, and APMAs new Director of Clinical Affairs. What we learned during the House of Delegates last spring and which was confirmed this past weekend, APMA is building and will have a Qualified Clinical Data Registry (QCDR). This QCDR will be approved by the government so that all APMA members will be able to submit these registry measures without problem. Conversely if a podiatrist is not an APMA member they will not have access to this QCDR – period.

This registry will collect ICD-10 and CPT codes on everything we do as podiatrists. As CMS moves away fee-for-service the profession will need to: (a) Improve quality of care; (b) Increase the value of our services to patients; (c) Reduce cost; (d) Improve safety; and (e) Demonstrate value of DPMs to CMS and the insurance companies.

APMA plans to elf-nominate this QCDR with CMS by 2017. APMA is already in talks with a number of electronic health record (EHR) companies to be on-board with the registry when it is launched. We were told APMA will reach out to as many EHR companies as is possible throughout 2017. Watch for information in this registry in the next two months from APMA.

During the CAC breakout session chaired by Mark Block, DPM, chair of APMAs Health Policy and Practice Committee, many items were covered that were issues from the MACs and from CAC representatives. We covered issues with DME especially the continuing denials via pre- and post-payment audits for diabetic therapeutic shoes and insoles. There were also issues with BK walkers in RI, CA and NM though NM has the same MAC as Texas and I am not aware of any issues in that regard here.

Pennsylvania, also a Novitas MAC state, seems to be having problems with mycotic nail debridement, but again and I am not aware of any issues in that regard here in Texas. Tennessee

is having trouble with Cahaba wanting the DPM to refer their patients to another practitioner every 30 days if they cannot get their patient's diabetic wound closed. And Iowa must take their deep ulcers (11043 and 11044) to the hospital for debridement as they cannot be performed in the office.

We also discussed in general the routine foot care and debridement of mycotic nail LCDs and the underlying Internet Only Manual rules governing these services. Also discussed was the implementation of the **–FX** modifier and the attendant fee reduction for those using film instead of digital X-rays. Another Novitas topic in the District of Columbia (Washington, DC) was the restriction of DPMs scope-of-practice by this MAC.

These topics were more informative than substantive so that all the CAC representative would understand what is going on around the country. It seems the MAC too talk among themselves and what we see in one region has a way of showing up in other regions and with other MACs.

The always interesting Medicare Part B Data (BMAD) is something I have always looked forward to hearing. This year David Freedman, DPM, the CAC representative from Maryland and a member of the APMA Coding Committee, again presented this data. He reported on the 2015 information which is the latest available to us from CMS.

In 2015 the Medicare Part B total allowed charges were $132.9 billion dollars. Of this total, claims submitted by podiatrists represented $2.16 billion or 1.6 percent. The top 300 procedures and services accounted for 93.2% of podiatric Medicare allowed charges in 2015. Medicare Part B had a total 2015 billed $132.9 Billion. This was an increase in allowed charges for all providers by 2 Billion compared to 2014. However there was a $20 million decrease in podiatric allowed charges and that amounted to a $50 million decrease in past 2 years. Claims submitted by podiatrists represented 1.6% of all Medicare claims in 2015; a drop from 1.7% in 2014.

Dr. Freedman reported the podiatry "owns" the bunion codes with DPMs billing 14,000 CPT code 28296 compared to orthopedists who billed about 2,000 in 2015. Similarly our profession owns the digital codes. DPMs billed more than 70,000 of CPT code 28285 procedures in 2015 compared to orthopedists who billed slightly more than 20,000.

Of interest was that podiatrists in 2015 billed 47,000 of 11765 which is excision of a skin wedge for an ingrown toenail. The nail itself is not touched in this procedure. I did not think this procedure was still being done or has been billed inappropriately by podiatrists who are not actually performing this procedure.

99203 ranks and the number one billed initial visit code three to one over 99202 and ten to one over 99201. Our profession billed 99204 only a third as much as 99203 and 99205 was only billed a tenth as much as 99203. For 99214 across specialties the one thing that sticks out again is podiatry bills a significant level of 99212 compared to dermatology, orthopedics and general surgery. These other professions are billing more 99214 and at a more equal and balanced level with 99212.

Between 2014 and 2015 CPT code 99212 ranking has remained 5th. Code 99213 ranking was up to 1st from 2nd. CPT code 99214 moved up 13th from 19th and 99203 remained same at 3rd ranked. Code 99202 too remained same as 12th ranked. The hospital visit codes (99221 – 99233) had moved up between 2010 and 2014, but fell slightly in 2015.

The wound care debridement codes 97597 and 97598 have more than made up for 11040 and 11041, but the fees associated with these codes have physicians receiving reduced fees for these two physical therapy codes.

The PQRS measures have some issues. There were podiatrists showing 30,000 colorectal screening were performed last year by podiatrists and that podiatrists reported performing a dilation retina exam. We know that neither of these is happening.

In 2015 the 986 podiatrists in Texas billed roughly the same as they had the prior year: $82,885,000 which represented 3.8% of all Medicare podiatry charges. This was interesting in that there had been a downward trend in number of DPM services; a downward trend in total allowed charges; and an increase in 2015 of the number of Medicare Advantage enrollees.

In 2014 the other peripheral nerve injections (64450) that podiatry performed represented 22.3% of that total. There was a change in 2015, as nurse practitioner surpassed us by performing 21.6% of the total billed charges compared to podiatry at 16.3%. Podiatry held steady in the number of 64455 (neuroma injections) billed between 2014 and 2015. We also held steady in the number of 64632 (neuroma sclerosing injections) billed between 2014 and 2015.

In 2015 the data showed a decrease in the total number of foot and toe amputations (28800, 28805, 28810, 28820, and 28825) of almost 9,000 amputations from 2014. These same amputation codes had been rising since 2012.

Texas podiatrists had the second highest number of 11755 (nail unit biopsy) codes billed in 2015 of almost 6,000 patients. I have been warning for some time that picking up debris off the tray and placing those nails in a specimen container does not qualify as a biopsy for any insurance company. The hammer will drop on those podiatrists at some point in time.

Fortunately Texas did not rank in the top 15 states for billing of 77077 (Joint Survey). As said in previous CAC reports, this is a service typically performed on pediatric patients and is certainly not performed in the foot or by podiatrists.

Based on the BMAD it seems DPMs have been appropriately using the –59 modifier when coding claims across the board.

For DME the A5500 diabetic extra depth shoes the history for the past four years shows in 2012 that podiatry was #1 billing profession at 37 million claims and 35% of the utilization. In 2013 podiatry was #1 at roughly 34.9% of the claims which was not a change, but the total allowed numbers decreased to 34.5 million. In 2014 podiatry was #1 with a 35% share, but the allowed charges dropped to $29,574,065. And in 2015 podiatry was still #1 at 35%, but again the allowed

charges dropped to $26,428,829. The medical supply companies decreased from 21.2% in 2012 to 20.4% in 2013 to 19.5% in 2014 and 18.4% in 2015.

For diabetic therapeutic shoes and insoles for 2010 podiatry was allowed $41,192,045 and that represented 33.9% with an average allowed charge of $67. In 2015 podiatry was allowed $26,428,829 that represented 35% with the average allowed charge of $70. In the past six years podiatry has seen the total allowed amount drop by 36%. For 2015 in all specialties the allowed number was 1,081,401 versus 1,826,426 2010 that represents a 41% drop in the number of allowed diabetic shoes and insoles.

The BMAD clearly shows that podiatrists still do not understand the verbiage has changed for walking boots. L4360 now represents prefabricated boots that require significant modifications where as L4361 are prefabricated boots that do not require any changes be made before dispensing them to the patient.

The L3000 series codes continue to show significant numbers across the DMEMAC regions. Remember all these L3000 series codes orthotic must be attached to a foot brace that runs up the leg and be part of (attached to) the shoe. These numbers should be so minuscule as to not cause the blip they do on the DME radar. If we know about these codes so do the Special Agents from the OIG and FBI. If you are billing patients the L3000 series codes those L3000 items should be billed to Medicare and paid since these are "statutorily non-covered" with a –GY modifier.

The data also again shows podiatrists billing L3908 for wrist-hand orthosis which is not an ankle foot orthosis. In the past 3 years the ranking for this code has gone up from 48th in 2014 to 45th in 2015. The BMAD also shows podiatrists billing for L2114 and L2116 which are tibial fracture orthoses. There is no foot or ankle component to either of these orthosis. I have to again ask are podiatrists really dispensing these devices or are they dispensing pneumatic walkers or non-pneumatic walkers and calling them tibial gracture AFO's? Please do not as I am sure others are looking at this billing abnormality as well.

And finally for some reason podiatrists continue to bill, as I have previously reported, for capesetabine. In 2015 it was allowed 1,109 times. This is an orally administered cancer chemotherapy agent. Dr. Freedman wondered if those using this code think it is Effudex? When he did a Google search he found it showed that others were searching for Effudex. This drug gets converted in the body to 5-fluorouracil. It has indications in colorectal cancer and breast cancer, so if podiatrists are using this it again is off label. But are podiatrist using the 5-fluorouracil for warts, but billing for capesetabine? My recommendation is do not use this code.

Jeff Lehrman, DPM gave the last lecture of the day on "Most Common Errors in E&M Coding." He reminded us that in the office a "new patient" is a patient who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. However in the hospital or nursing home an "initial encounter" and note the difference between the terms new patient and initial encounter. The inital encounter is first time you have seen the patient during that admission regardless of if or when you had seen that patient previously.

Remember too that you cannot use consultation codes (99241 – 99255) with any Medicare patient. A consultation is when another physician requests only your opinion or advice. At that time the consultant offers his/her opinion or advice and sends patient back to the referring physician. A consultant may initiate diagnostic and/or therapeutic services (Current Procedural Terminology 2013, AMA), but you cannot bill for a consultation with when you take over complete care of the patient for that problem. The key factor is if the referral is a consult or a transfer of care.

The history contains a: chief complaint, the history of present illness (HPI), the past medical history, the past family history and a social history. Also contained in the history is the review-of-systems. The review-of-systems is a subjective questioning of the patient that goes something like, "Have you recently experienced "X." It is not a repeat of the HPI and you cannot say, "see HPI." If you review 1-9 systems you will need to document all positives and pertinent negative for each system. However if you review 10 systems you must individually document systems with positives and pertinent negatives and you may document all others "negative."

A review-of-systems might generally contain some of the following findings:
Constitutional: N/F/V/C/Weakness/Fatigue
Eyes: Diplopia/Glaucoma/Cataracts/Spots
ENT: Tinnitus/Vertigo/Sinusitis/Dentition
CV: SOB/CP/Murmurs/Fainting
Respiratory: Wheezing/Hemoptysis/Cough/Pleurisy
GI: Reflux/Diarrhea/Constipation/Hemorrhoids
GU: Hematuria/Nocturia/Polyuria/Dysuria
Musculoskeletal: Pain/Edema/Erythema/Stiffness
Integumentary: Lesions/Rashes/Lumps/Bumps
Neurologic: Weakness/Paralysis/Numbness/Tingling
Psychiatric: Hallucinations/Voices/Suicidal thoughts
Endocrine: Hypo/Hyperthyroid/Temp Imbalance
Hematologic: Anemia/Bruising/Bleeding
Allergic/Immunologic: Wheezing/Hives/Itching/Runny Nose

The physical exam, based on the 1997 CPT system of bullets is categorized as:

- 1 Bullet
- 6 Bullets
- 12 Bullets
- One entire Organ System (OS)

Podiatrists must perform the general multipurpose examination since there is no podiatry specific examination available in CPT. This general exam covers the following OS:

- Cardiovascular
- Ears, Nose, Mouth and Throat
- Eyes
- Genitourinary (Male)
- Genitourinary (Female)
- Constitutional Neurological

- Musculoskeletal
- Psychiatric
- Respiratory
- Skin
- Hematologic / Lymphatic / Immunologic

For medical decision-making (MDM) you should be covering: (a) the possible diagnoses and/or treatment(s); the treatment options; the amount and/or complexity of any data that you have reviewed; and the risk of complications, morbidity and/or mortality. There is a numbering system to determine the MDM. For the possible diagnoses and/or treatment(s) you count the number of each that are considered with one being minimal; two is limited; 3 as multiple; and four is extensive. For the treatment options the numbering system is: one for a minor, stable, or improving problem; two for an established problem which is worsening; three for a new problem with no additional work up planned; and four for a new problem with additional work up planned.

Under the amount and/or complexity of any data that you have reviewed you should be looking at: (a) the diagnostic tests you have ordered or reviewed; (b) any old medical records you reviewed; and (c) any history you obtained from sources other than the patient. This section would include a review of any ordered lab tests, radiology tests, medicine tests (EKG), obtaining old records and/or discussing these results with physician who performed those test. It could also include your review of imaging tests previously performed or a summation of your old medical records on the patient. The point system for the data reviewed is: One for minimal or none; two for limited data reviewed; three points for a moderate amount of data reviewed; and four for an extensive amount of reviewed data.

The risk of complications, morbidity and/or mortality is based on presenting problem and management options. It is also based on your documented comorbidities that things that would complicate the treatment options. There is also a well know "Table of Risk" that can be used, but will not be reproduced here.

So minimal risk encompasses one element in any of the following three categories:

Presenting Problem(s)

One self-limited or minor problem (e.g., insect bite, cold)

Diagnostic Procedure(s)

Lab tests
Chest X-ray
EKG/EEG
Urinalysis
Ultrasound/Echocardiography
KOH prep / fungal prep or test

Management Options Selected

Rest
Gargles
Elastic bandages
Superficial dressing

A low risk requires one element in any of the following three categories:

- Presenting Problem(s)
  - Two or more self-limited or minor problems
  - One stable chronic illness
  - Acute uncomplicated illness or injury (allergic rhinitis, ankle sprain, cystitis)
- Diagnostic Procedure(s)
  - Physiologic tests not under stress (e.g., PFTs)
  - Non-cardiovascular imaging studies with contrast (e.g., barium enema)
  - Superficial needle biopsies
  - ABGs
  - Skin biopsies
- Management Options Selected
  - Over-the-counter drugs
  - Minor surgery with no identified risk factors
  - Occupational therapy
  - Physical therapy
  - IV fluids without additives

Moderate risk requires one element in any of the following three categories:

- Presenting Problem(s)
  - One or more chronic illness with mild exacerbation or progression
  - Two or more stable chronic illnesses
  - Undiagnosed new problem with uncertain prognosis (e.g., lump in breast)
  - Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis
  - Acute complicated injury (e.g., head injury with brief loss of consciousness)
- Diagnostic Procedure(s)
  - Physiologic tests under stress (e.g., cardiac stress test)
  - Diagnostic endoscopies with no identified risk factors
  - Deep needle or incisional biopsies
  - Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)
  - Obtain fluid from body cavity (e.g., LP, thoracentesis, culdocentesis)
- Management Options Selected
  - Minor surgery with identified risk factors
  - Elective major surgery with no risk factors
  - Prescriptions drug management
  - Therapeutic nuclear medicine
  - IV fluids with additives
  - Closed treatment of fracture or dislocations without manipulation

High risk too requires one element in any of the following three categories:

- Presenting Problem(s)
  - One or more chronic illness with severe exacerbation or progression

- Acute or chronic illness or injuries which pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure)

Diagnostic Procedure(s)

- Cardiovascular imaging studies with contrast with identified risk factors
- Cardiac EP testing
- Diagnostic endoscopies with identified risk factors
- Discography

Management Options Selected

- Elective major surgery with identified risk factors
- Emergency major surgery
- Parenteral controlled substances
- Drug therapy requiring intensive monitoring for toxicity
- Decision not to resuscitate or to de-escalate care because of poor prognosis

Remember that you will need three of the three key component (history, physical exam and MDM) for a new patient exam and two of these three key components for an established patient exam.

One last point is the greater than 50% rule. In that rule If you spend "X" minutes with the patient and greater than 50% of that time was spent in counseling and/or coordination of care you get to bill the E/M code based on time alone. In the office it is face to face time with patient and/or family, but in the hospital or nursing home it is face to face time plus floor/unit time. You must state in your note how much time you spent by saying that "X" face-to-face time was spent with the patient in counseling and/or coordination of care out of a total time of "X" minutes. Your medical record must reflect those items in some substantial detail you covered in those discussions.

I have included a hand-out from Dr. Lehrman that you can download from the TPMA site for your reviewe.