Course Objectives

Document Components of E&M:
- Chief Complaint/Reason
- History
- Examination
- Medical Decision-Making
References

- National Government Services
- https://www.ngsmedicare.com

- LCD (Local Coverage Determination) for OMT L33616

- ICD10 Official Guidelines for 2020

- American Osteopathic Association: GUIDE TO CODING & DOCUMENTATION: OSTEOPATHIC MANIPULATIVE TREATMENT, FIRST EDITION
Osteopathic Manipulative Treatment specifically encompasses only the procedure itself. E&M services are covered as a separate and distinct service when medically necessary and appropriately documented.

If a significant, separately identifiable evaluation and management service above and beyond the osteopathic manipulation service is provided, this must be indicated by reporting modifier 25 to the E&M service code.

OMT utilized at a follow-up visit is not the same as follow-up OMT. A follow-up visit for OMT is a predetermined service and would not support another E/M (for the same problem).

A follow-up visit where OMT is utilized is not necessarily predetermined unless the preceding progress note denoted it to be an OMT visit.
E/M with OMT

- E/M services may be separately reported with modifier 25 appended, if the patient’s condition requires a significant, separately identifiable E/M service above and beyond the usual pre- and post-service work associated with the treatment. Different diagnoses are not required for the reporting the OMT service and E/M service on the same date.

- If an E/M service is being reported on the same day as OMT, the documentation should clearly distinguish the services that constitute the E/M service, which include an appropriate **history, physical exam, as well as assessment and plan.**
Pre and Post Service Work

- The preservice work for OMT includes determining which techniques and in what order the affected body regions will be treated. Preservice work also includes explaining the treatment to the patient, answering patient questions, and positioning the patient.

- Postservice work includes postcare instructions related to the procedure that are provided to the patient (eg, possible side effects, self care) and documentation of the treatment in the medical record.
No E&M service is warranted for previously planned follow-up OMT treatments. Examples include:

1. If a patient is scheduled for a defined number of follow-up OMT treatments for an episode of care, no E/M should be reported on those dates of service unless a new condition occurs or the patient’s condition has changed substantially, necessitating an overall reassessment of the treatment plan;

2. If a patient is seen and the E/M service determines that OMT is indicated, but the patient must be scheduled to receive the OMT the following day due to time constraints, no E/M should be reported on the following day unless the patient’s condition has changed substantially. The medical record should clearly document this.
Clarify Intent of Visit

- **Clarify intent of visit.**
- **What did the preceding progress note indicate?**
- A follow-up visit for OMT is a predetermined service and would not support another E/M (for the same problem).
- A follow-up visit where OMT is utilized is not necessarily predetermined unless the preceding progress note denoted it to be an OMT visit.

- **If not clear, the E/M will not be supported.**
Example 1 Was this part of multiple treatments planned vs. a reassessment?

Subjective
Pt presents to the clinic for OMT.
expanded/detailed problem focus:
Current Pain: 3-4/10
Pain with Rotation: 3-4/10
areas affected: medial shoulder blade, neck, thoracic spine, shoulder capsule
Pt reports that pain is equal on both sides

makes it worse: movement
makes it better: rest, acupuncture
began with: studying and jujitsu training
The pain does not affect pt's sleep pattern.
The pain affects everyday tasks.
Able to work due to pain.
Range of motion: slightly restricted

Pt reports that they had improvements in range of motion and pain levels for the first 4 days after their last treatment
Pt had their flu shot earlier this season.
Pt has no additional questions or concerns.
TD
Chief Complaint

- Ensure the chief complaint/reason for visit is documented within the history section and clarifies the intent of the visit. This establishes the medical necessity for the services.
- This may be stated as the chief complaint, or indicated within the history of present illness.
E/M with OMT

Chief Complaint/History Section examples:

• The purpose of the E/M service that was provided was to evaluate a specific complaint or problem.

• Describe how and when the patient’s condition has substantially changed or that the reassessment of the problem or treatment plan is necessary.

• The patient’s visit was not scheduled for the explicit purpose of performing OMT on that date.
Established patient returns to the office for re-evaluation of continued low back pain, which was previously relieved with OMT and has become (or still is) painful again. Additional symptoms, including tingling noted, with some radiation to legs. He feels stiff and achy if he tries to do his normal daily activities. He is still taking aspirin with minimal relief.

Re-evaluation is required to determine appropriate treatment.

HPI: location = low back, severity= still painful, modifying factor = minimal relief with ASA, associated sign/symptom = radiation to legs

ROS x 2 : tingling, stiff, achy

Past hx: meds ASA

History is detailed with 4 HPI, 2 ROS, past hx
<table>
<thead>
<tr>
<th>Encounter Reason/Date</th>
<th>Left leg pain, Bilateral low back pain 03/06/2019 - 03:20PM - [Redacted]</th>
</tr>
</thead>
</table>
| History of Present Illness | Musculoskeletal Pain  
Reported by patient.  
Location: left foot (heel)  
Quality: tingling; aching; numbness; swollen  
Severity: same; pain level with meds 0/10; pain level without meds 5/10; foot numbness  
Timing: intermittent; after gardening  
Context: setting fence posts in his garden  
Alleviating factors: rest  
Aggravating factors: movement/positioning; Walking, weight bearing  
Associated Symptoms: tingling; numbness of the legs/feet; swelling |
| Knee | Reported by patient.  
Location: bilateral; posterior  
Quality: aching; occasional; improving  
Severity: mild; pain level 0/10; worst pain 4/10  
Duration: date of onset: 10/18/16; 2 years; continuous since onset  
Timing: acute  
Context: twisting  
Alleviating Factors: position change; rest  
Aggravating Factors: twisting; ROM; weightbearing  
Associated Symptoms: no weakness; no numbness; no tingling  
Previous Surgery: none  
Prior Imaging: none  
Previous Injections: none  
Previous PT: none  
Work Related: no  
Working: regular duty |
| Pain Management L-spine | Reported by patient.  
Location: radiating to the L LE; LBP (tight on the left)  
Quality: tightness; numbness  
Severity: current pain level 5/10; worst pain 8/10; improving; same; interference with sleep; leg |
Key Component #1: History

The extent of history of present illness, review of systems and past family and/or social history obtained and documented is dependent upon clinical judgment and the nature of presenting problem(s).

- History is comprised of some or all of the following elements:
  - Chief Complaint (CC)
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family and/or Social History (PFSH)
The Elements of Present Illness are:

- location
- quality
- severity
- duration

- timing
- context
- modifying factors
- associated signs and symptoms

**Types of HPI**

**Brief**
1-3 elements have been documented

**Extended**
At least 4 elements or the status of at least 3 chronic or inactive conditions have been documented.
HPI Elements Defined:

- **Location**
  - Site of the symptoms “where”, exact location of problem.
  
  Examples:
  
  *Low back pain*
  *R leg pain*

- **Quality**
  - Features, characteristics or attributes of a symptom.
  - What does the problem look, feel or sound like?

  Examples: *Pain – sharp, dull, radiating, throbbing, stabbing*
HPI Elements Defined:

- **Severity**
  - Hardness, sharpness, intensity of pain on a scale of 1-10. (Severity is also a quality.)
  
  *Examples:*
  - Pain on scale of 1-10
  - “Patient feeling better”

- **Duration**
  
  *Examples:*
  - For 1 week
  - 2 days ago

- **Timing**
  - Regularity of an occurrence, relationship to something else, why and when does the problem occur.
  
  *Examples:*
  - During the night
  - Frequent
  - Comes and goes
  - All the time
HPI Elements Defined:

- **Context**
  - How the complaint occurred, circumstances surrounding a complaint; what precedes or follows a symptom.
  - Under what circumstance did the patient first notice the problem?
  
  **Examples:**
  - Hurt back in a motorcycle accident.
  - Fell from tree.
  - While sleeping,
  - After lifting a heavy box

- **Modifying Factors**
  - Factors that alter, limit, change or reduce a symptom.
  - What makes the symptom worse or better?

  **Examples:**
  - OTC meds not helping pain
  - Pain is better since her surgery.

- **Associated Signs and Symptoms**
  - Factors that accompany the main symptom.
  - What other symptoms are present?

  **Examples:**
  - Stiffness, tingling
An inventory of body systems obtained through a series of questions to identify signs and/or symptoms which the patient may be experiencing or has experienced. The following 14 systems are recognized:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Integumentary (skin and/or breast)
- Musculoskeletal
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic
Complete ROS

- For new patient visits 99204 and 99205, or consults 99244 and 99245 a complete ROS is required. At least ten organ systems must be reviewed. **Those systems with positive or pertinent negative responses must be individually documented.**

- For the remaining systems, a notation indicating “all other systems have been reviewed and are negative” is permissible. In the absence of such a notation, at least ten systems must be individually documented.
All other systems have been reviewed and are negative.

The remainder of the systems were reviewed and are negative.

ROS was obtained and except as listed in the HPI, all other systems are negative.

A complete review of systems was otherwise negative.
Inappropriate Reference for a Complete ROS

**Do not just state:**

- ROS negative
- ROS is unremarkable.
- ROS is noncontributory
Past History

A review of the patient’s past experience or lack thereof with illnesses, injuries and treatments that include significant information about:

- prior major illnesses and injuries
- prior operations
- prior hospitalizations
- current medications
- allergies (drug, food)
- age appropriate immunity status
- age appropriate feeding/dietary status
- pregnancy history
- growth history
- functional status history
A review of medical events in the patient’s family, including diseases of family members which may be hereditary or place the patient at risk.
Unacceptable Family History Documentation

- Family history noncontributory
- No change.
Acceptable Family History Documentation

- Family history reviewed and is non-contributory to this illness/condition.
- Family history unchanged since May 31, 2017.
- No family history of joint disorders.
- Patient adopted. Family history unknown.
Social History

An age-appropriate review of past and current activities that includes significant information about:

- marital status and/or living arrangements
- current employment
- occupational history
- **military history**
- use of drugs, alcohol and tobacco
- level of education
- sexual history
- other relevant social factors
Physical examination must indicate the presence of somatic dysfunction of one or more regions (appropriately documented in the medical record).

Documentation of examination findings of somatic dysfunction should describe pathology in the areas of the skeletal, arthroidal and myofascial structures as well as related vascular, lymphatic and neuroelements.

The diagnosis of somatic dysfunction is made by determining the presence of one or more findings described by the acronym TART (Tenderness, Asymmetry, Restriction of Motion and Tissue Texture Abnormality).
The physician should document any change in pain or function along with the presence of somatic dysfunction, which may include but is not limited, to the following:

- range of motion
- gait
- use of assistive device or absence of assistive device
- balance
- ability to walk without pain or difficulty (e.g., distance)
- measurement of improvement or decline using a scoring system and threshold intervals for each measurement
EXAM

Constitutional: General Appearance: healthy-appearing, well-nourished, and well-developed.

Mental Status: Mental Status: normal mood and affect and active and alert. Orientation: to time, place, and person.

Lungs: Respiration: no dyspnea and good air movement. Percussion: no dullness, flatness, or hyperresonance. Auscultation: breath sounds normal and no wheezing.

Cardiovascular System: Heart Auscultation: RRR. Pulses peripheral (normal) radial and pulse; popliteal; and posterior tibial pulse normal and normal dorsalis pedis; no peripheral edema, good capillary refill.

Musculoskeletal System: Lower Extremities: no dysfunction Quadriceps or Piriformis; no edema; and decreased range of motion left hip: extension, and Hamstrings dysfunction: left. Cervical Spine: C4: extended sidebent right rotated right tender point right and fascial restrictions: right, anterior, and negative Spurling's maneuver bilateral, no hypertonicity, and normal lordosis. Lumbar Spine: lumbar spine hypertonicity (spasms with motion and stretch), L4: extended sidebent left, rotated left tender point left, L5: extended tender point bilateral, and muscle dysfunction: paravertebrals bilaterally, and negative straight-leg raising test bilateral, no dysfunction Psoas, and normal lordosis. Hips: no dysfunction Tensor Fascia Lata. Knees: no ligamentous instability on examination. Thoracic Spine thoracic spine hypertonicity (splitting lower thoracic due to pain and lumbar spine), T9: extended sidebent left, rotated left tender point left, T12: flexed tender point bilateral, and muscle dysfunction: paravertebrals bilateral. Sacrum: no dysfunction Gluteus Maximus or Gluteus Medius and tender point SI joint left upper pole (significant inflammation) and decreased SI junction motion left Pelvis posterior innominate: right, fascial restrictions deep, posterior, and Iliacus muscle dysfunction bilateral, and normal motion and no dysfunction Iliacus. Ribs: normal function with breathing and no dysfunction serratus anterior. Upper Extremity: no dysfunction Supraspinatus, Infraspinatus, Subcapularis, Coracobrachialis, Teres Minor, or Middle Deltoid.


There are **four (4)** types of examination. These exams have been defined for general multi-system and ten (10) single organ systems.

**PROBLEM FOCUSED**

- Limited exam of the affected body area or organ system.

**EXPANDED PROBLEM FOCUSED**

- Limited exam of affected body area or organ system and other symptomatic or related body area(s) or organ system(s).
Key Component #2: Examination

**DETAILED**

- An extended exam of the affected body area(s) or organ system(s) and other symptomatic or related body area(s) or organ system(s).

**COMPREHENSIVE**

- A general multi-system exam or a complete exam of a single organ system and other symptomatic or related body area(s) or organ system(s).
Body Areas:

- Head, including the face
- Neck
- Chest, including the breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity
Organ Systems:

- Constitutional
- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
1995 Guidelines

Problem Focused Exam
* 1 body area or organ system

Expanded Problem Focused Exam
* 2-7 body areas or organ systems

Detailed Exam
* 2-7 body areas or organ systems
  (Discuss 2 body areas or organ systems in greater depth.)

Comprehensive
* 8 or more organ systems
Detailed Exam = 2-7 body areas or systems (expanded documentation of the areas and/or systems examined; requires more than checklists; needs to have normal/abnormal findings expanded upon)

Recommendation:
- 2 or more items for 2 or more body areas or organ systems, one of which must be related to the presenting problem = DETAILED exam.

- Musculoskeletal- 1) Focal exam of right shoulder demonstrates tenderness over the bicipital tendon on the right  2) No palpable deformity, no crepitus with range

- Neuro - 1) Strength 5 out of 5  2) Sensory exam demonstrates diminished sensation to his feet  3) Gait is stable, able to heel and toe walk
Physical Examination:

**General:** The patient appears the stated age; body habitus is normal.

**Eyes:** Pupils are equal, round, reactive to light, and with no evidence of narcotism.

**Cardiovascular:** No significant swelling or edema is noted on inspection and palpation.

**Abdomen:** Soft, nontender, nondistended, no rebound.

**Skin:** Head, neck, trunk and all four limbs did not reveal scars or lesions.

**Psychiatric:** Alert and oriented x3; affect and mood are normal.

**Neurologic/Sensory:** There is normal light touch sensation in the bilateral upper and lower limbs. MMT revealed 5/5 strength both proximally and distally in the bilateral upper and lower limbs. Muscle stretch reflexes were 2+ and symmetric in bilateral upper and lower limbs. Upper motor neuron signs are negative bilaterally. Gait is antalgic with a normal base.

**Musculoskeletal:** Inspection, palpation, range of motion, and assessment for instability of the head, neck, trunk, and all four extremities reveals no gross abnormalities except for decreased range of motion of the right hip as well as the lumbar spine. He has tenderness in the medial and lateral joint lines of the right knee.

Special Tests: Bilateral knee extensions are normal. Bilateral flexions are achieved.

www.codingnetwork.com © 2019
The Coding Network, LLC
### Musculoskeletal Examination

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem Focused</strong></td>
<td><strong>One to five</strong> elements identified by a bullet.</td>
</tr>
<tr>
<td><strong>Expanded Problem Focused</strong></td>
<td><strong>At least six</strong> elements identified by a bullet.</td>
</tr>
<tr>
<td><strong>Detailed</strong></td>
<td>At least 12 <strong>elements identified by a bullet.</strong></td>
</tr>
<tr>
<td><strong>Comprehensive</strong></td>
<td>Perform <strong>all</strong> elements identified by a bullet; document every element in a shaded box and at least one element in each unshaded box.</td>
</tr>
</tbody>
</table>
1997 Exam Musculoskeletal

SPECIALTY EXAM: MUSCULOSKELETAL

Refer to data section (table below) in order to quantify. After reviewing the medical record documentation, identify the level of examination. Circle the level of examination within the appropriate grid in Section 5 (Page 3).

<table>
<thead>
<tr>
<th>Performed and Documented</th>
<th>Level of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to five bullets</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Six to eleven bullets</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Twelve or more bullets</td>
<td>Detailed</td>
</tr>
<tr>
<td>All bullets</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

(Circle the bullets that are documented.)

NOTE: For the descriptions of the elements of examination containing the words "and", "or", 
and/or", only one (1) of those elements must be documented.

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness).</td>
</tr>
<tr>
<td>Lymphatic</td>
<td>Palpation of lymph nodes in neck, axilla, groin, and/or other location.</td>
</tr>
<tr>
<td>Extremities</td>
<td>(See Musculoskeletal and Skin)</td>
</tr>
</tbody>
</table>

| Skin             | Inspection and palpation of skin and subcutaneous tissue (e.g., acral, rash, lesions, café-au-lait spots, ulcers) in four of the following six areas: 1) head and neck, 2) trunk, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, and 6) left lower extremity. |
| Neurological/Psychiatric | Test coordination (e.g., fingernails, handwriting), rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children. |
|                  | Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski). |
|                  | Examination of sensation (e.g., by touch, pin, vibration, proprioception). Brief assessment of mental status including: Orientation to time, place and person Mood and affect (e.g., depression, anxiety, agitation). |

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, height, 7) weight (may be measured and recorded by ancillary staff). General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming).</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Examination of gait and station (% circled, add to total at bottom of column to the left) Examination of joint(s), bone(s) and muscle(s) (tendon(s) of four of the following six areas: 1) head and neck, 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; 6) left lower extremity. The examination of a given area includes:</td>
</tr>
<tr>
<td></td>
<td>Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, erasure, callus, tenderness, masses or effusions. Assessment of range of motion with notation of any pain (e.g., straight leg raising), erasure or contracture.</td>
</tr>
<tr>
<td></td>
<td>Assessment of range of motion with notation of any pain (e.g., straight leg raising), erasure or contracture.</td>
</tr>
<tr>
<td></td>
<td>Assessment of range of motion with notation of any adduction (laxation), subluxation or laxity.</td>
</tr>
<tr>
<td></td>
<td>Assessment of muscle strength and tone (e.g., fascic, cog wheel, spastic) with notation of any asymmetry or abnormal movement.</td>
</tr>
<tr>
<td></td>
<td>Assessment of muscle strength and tone (e.g., fascic, cog wheel, spastic) with notation of any asymmetry or abnormal movement.</td>
</tr>
<tr>
<td></td>
<td>For the comprehensive level of examination, all four elements identified by a bullet must be performed and documented for each of the four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two activities constitutes two elements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXAM</th>
<th>One to Five Bullets</th>
<th>Six to Eleven Bullets</th>
<th>Twelve or More Bullets</th>
<th>All Bullets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Exam</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

Note: The Chest (Breasts); Gastrointestinal (Abdomen); Genitourinary; Head/Face; Eyes; Ears; Nose; Mouth and Throat; Neck and Respiratory system/body areas are not considered to be part of this Musculoskeletal exam.
Exam-Key Components

- **1995 guidelines**
  - Count the number of body areas/systems
  - Single system exams are not defined
  - Documentation requirements are less stringent

- **1997 guidelines**
  - Count the number of elements/bullets performed in single organ system and other pertinent systems
  - Harder to meet without templates/macros
Specific abnormal and relevant negative findings of the examination should be documented. A notation of “abnormal” without elaboration is insufficient.

The exam is real time. One cannot indicate “no change in the exam from previous encounter” for the entire exam.
Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option. The complexity of the assessment and plan of care for a patient is measured by:

- number of possible diagnoses and/or management options
- amount and complexity of medical records, diagnostic tests and other data to be obtained, reviewed and analyzed
- risk of significant complications, morbidity and mortality
Assessment/Plan

- Document an Assessment and Plan to support the medical decision making component of the E/M service. The physician can support their diagnosis of somatic dysfunction and their decision to perform OMT.
### Assessment and Plan:

The patient has been having significant difficulty with lower thoracic and low back pain and spasms with radiation into the lower extremity after lifting multiple books and moving a bookshelf. Stiffness in neck and upper back are also present affecting sleep patterns and fatigue levels. OMT is provided to reduce pain and spasms and improve function with good results. Patient is not to lift or twist with anything greater than 5 pounds for the next 3 days.

1. **Displacement of lumbar intervertebral disc without myelopathy**
   - M51.28: Other intervertebral disc displacement, lumbar region
     - HERNIATED DISC: CARE INSTRUCTIONS

2. **Sciatica**
   - M54.32: Sciatica, left side
     - SCIATICA: CARE INSTRUCTIONS

3. **Neck pain**
   - M54.2: Cervicalgia
     - NECK PAIN: CARE INSTRUCTIONS

4. **Inflammation of sacroiliac joint**
   - M46.1: Sacroilitis, not elsewhere classified
     - SACROILIAC PAIN: EXERCISES

5. **Somatic dysfunction of lumbar region**
   - M99.03: Segmental and somatic dysfunction of lumbar region

6. **Somatic dysfunction of sacral spine**
   - M99.04: Segmental and somatic dysfunction of sacral region

7. **Somatic dysfunction of pelvic region**
   - M99.05: Segmental and somatic dysfunction of pelvic region

8. **Somatic dysfunction of thoracic region**
   - M99.02: Segmental and somatic dysfunction of thoracic region

9. **Somatic dysfunction of lower limb**
   - M99.06: Segmental and somatic dysfunction of lower extremity
There are **four (4)** types of medical decision-making. To qualify for a given type of medical decision-making, criteria for **two of the three tables** must be either met or exceeded.
<table>
<thead>
<tr>
<th>Number of diagnoses or management options (per points)</th>
<th>Amount and/or complexity of data obtained, reviewed, and analyzed (per points)</th>
<th>Risk of complications and/or morbidity or mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (1)</td>
<td>Minimal or none (1)</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited (2)</td>
<td>Limited (2)</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple (3)</td>
<td>Moderate (3)</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive (≥4)</td>
<td>Extensive (≥4)</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
The number of possible diagnoses and/or the number of management options that must be considered is based on:

- The number and types of problems addressed during the encounter;
- The complexity of establishing a diagnosis; and
- The management decisions that are made by the physician.

Layman’s Terms: What’s wrong with the patient? How many and what type of diagnoses are there on this visit?
### MDM Table #1:

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Limited, Minor (Max=2)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner): stable/improved</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner): that is inadequately controlled, worsening, or failing to progress as expected</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner): no additional workup (Max=1)</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner): additional workup planned</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total =</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DIAGNOSIS OR MANAGEMENT OPTIONS

- For each encounter, an assessment, diagnosis or clinical impression should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- Indicate whether patients with established diagnoses are improving, well-controlled, resolving or resolved, inadequately controlled, worsening, or failing to change as expected.
A) New Patient:
   - New problem with no additional workup (3)
   - New problem with additional workup (4)

   ✤ Additional tests or diagnostic studies
   ✤ Request for consult
   ✤ Need to review records of requesting/treating physician
   ✤ Additional workup includes those efforts necessary to develop a diagnosis or to determine a course of treatment.
Established patient with multiple problems:

- 1) **Neck pain/stiffness:** somatic dysfunction cervical region still present, OMT to reduce pain and improve function

- 2) **Sciatica right side:** somatic dysfunction lumber region not resolving, OMT to reduce pain and spasms and improve function. (supports decision for OMT following evaluation vs. pre-determined).

List each problem addressed and/or treated individually. Document the status/plan for each.

**Note:** Diagnoses listed in the A/P but not otherwise supported with a status or treatment plan are not considered when assigning a level of service. **Do not choose ICD10 codes from the problem list if not addressed in the visit.**
Assessment

Cervical thoracic radiculopathy
Musculoskeletal pain syndrome secondary to complex spinal alterations from idiopathic kyphoscoliosis, acquired stenosis, multiple somatic dysfunctions and spondylotic changes.
Myofascial Pain Syndrome/Myalgia/multiple trigger points
Osteoarthritis
Chronic lymphocytic leukemia
Personal history of cervical cancer
Hyperlipidemia
<table>
<thead>
<tr>
<th>MDM Table #2: AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED</th>
</tr>
</thead>
<tbody>
<tr>
<td>✤ Review/order clinical lab test(s)</td>
</tr>
<tr>
<td>✤ Review/order imaging studies</td>
</tr>
<tr>
<td>✤ Review/order medicine test(s) PFT, ECG, echoes, cardiac caths</td>
</tr>
<tr>
<td>✤ Discuss results with performing MD (contradictory or unexpected results)</td>
</tr>
<tr>
<td>✤ Decision to obtain and review old records and/or obtain history from someone other than patient.</td>
</tr>
</tbody>
</table>
MDM Table #2: AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

- Review and summarize old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider

- Independent review of image, tracing or specimen (often supplements information from physician who prepared test report or interpretation)
| Points | Review/order clinical lab test(s) | max=1 | 1 |
| Points | Review/order imaging studies | max=1 | 1 |
| Points | Review/order diagnostic test(s) from medicine section | max=1 | 1 |
| Points | Discuss results with performing MD | 1 |
| Points | Decision to obtain old records | 1 |
| Points | Review and summarize old records | 2 |
| Points | Obtain history from someone other than the patient | 2 |
| Points | Independent review of image, tracing or specimen | 2 |
| Points | Discussion of case with another health care provider | 2 |
Recommended language:

- I have reviewed records from (document where records came from) and the summary is as follows: (i.e., brief summarization of outside consult notes, hospitalization treatment management).
- I have personally reviewed and interpreted (state the type of specimen, image or tracing) and my findings are ______________.
- I will request records from (document the name of the hospital or doctor’s office).
- I will order and/or recommend the following (document all tests ordered and procedures that will be performed).
The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the following categories:

- Presenting problem(s);
- Diagnostic procedure(s); and
- Possible management options.
<table>
<thead>
<tr>
<th>The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.</td>
</tr>
<tr>
<td>The highest level of risk in any one category determines the overall risk.</td>
</tr>
</tbody>
</table>
RISK OF COMPLICATIONS, MORBIDITY AND/OR MORTALITY

❖ Comorbidities/underlying diseases or other factors that increase the complexity of medical decision-making by increasing the risk of complications, morbidity and/or mortality should be documented. Examples include diabetes mellitus, hypertension, HIV and anti-coagulation therapy.

❖ If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E&M encounter, the type of procedure, e.g., laparoscopy, should be documented.

❖ If a surgical or invasive diagnostic procedure is performed at the time of the E&M encounter, the specific procedure should be documented.
# Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| Minimal       | One self-limited or minor problem (e.g., cold, insect bite, venipuncture, tinea corporis) | Laboratory tests requiring:  
- Chest x-rays  
- EKG/EEG  
- Urinalysis  
- Ultrasound (e.g., echocardiography)  
- KOH prep | Rest  
Gargles  
Elastic Bandages  
Superficial Dressings |
| Low           | Two or more self-limited or minor problems  
One stable chronic illness (e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH)  
Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain) | Physiologic tests not under stress (e.g., pulmonary function tests)  
Non-cardiovascular imaging studies with contrast (e.g., barium enema)  
Superficial needle biopsies  
Clinical laboratory tests requiring arterial puncture  
Skin biopsies | Over-the-counter drugs  
Minor surgery with no identified risk factors  
Physical therapy  
Occupational therapy  
IV fluids without additives |
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>✦ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>✦ Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</td>
<td>✦ Minor surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>✦ Two or more stable chronic illnesses</td>
<td>✦ Diagnostic endoscopies with no identified risk factors</td>
<td>✦ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>✦ Undiagnosed new problem with uncertain prognosis</td>
<td>✦ Deep needle or incisional biopsy</td>
<td>✦ Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>✦ Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis)</td>
<td>✦ Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</td>
<td>✦ Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✦ Obtain fluid from body cavity (e.g., lumbar puncture, thoracentesis, culdocentesis)</td>
<td>✦ IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>✦ Closed treatment of fracture or dislocation without manipulation</td>
</tr>
</tbody>
</table>
## Table of Risk Cont’d

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| High          | ⊘ One or more chronic illnesses with **severe exacerbation**, progression, or side effects of treatment  
                ⊘ Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure  
                ⊘ **An abrupt change in neurologic status** (e.g., seizure, TIA, weakness, sensory loss) | ⊘ Cardiovascular imaging studies with contrast with identified risk factors  
                                                                                     ⊘ Cardiac electrophysiological tests  
                                                                                     ⊘ Diagnostic endoscopies with identified risk factors  
                                                                                     ⊘ Discography | ⊘ Elective major surgery (open, percutaneous or endoscopic) with identified risk factors  
                                                                                     ⊘ Emergency major surgery (open, percutaneous or endoscopic)  
                                                                                     ⊘ Parenteral controlled substances  
                                                                                     ⊘ Drug therapy requiring intensive monitoring for toxicity  
                                                                                     ⊘ Decision not to resuscitate or to de-escalate care because of poor prognosis |
EXAMPLE MDM: L shoulder pain, stable, >new symptom low back pain

### 3. Medical Decision Making

**Number of Diagnoses or Treatment Options**

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(stable, improved or worsening)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New prob. (to examiner); add. workup planned</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to line A in Final Result for Complexity (table below)
**Example MDM: Order lab, indep review**

### Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total** 3

Bring total to **line C** in Final Result for Complexity (table below).
## EXAMPLE MDM

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate level(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table above).

<table>
<thead>
<tr>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>the self-limited or minor problem, insect bite, tinea corporis</td>
<td>Laboratory tests requiring venipuncture, Chest x-rays, EEG, Urinalysis, Ultrasound, e.g., echo, KOH prep</td>
<td>Rest, Gargles, Elastic bandages, Superficial dressings</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Two or more self-limited or minor problems One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, urinary tract uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Physiologic tests not under stress, e.g., pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g., barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies</td>
<td>Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., lump in breast Pulmonary, systemic symptoms, e.g., pneumonia, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or health function, e.g., multiple trauma, acute MI, meningitis, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss</td>
<td>Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography</td>
<td>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
**Final Result for Complexity**

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th></th>
<th>Number diagnoses or treatment options</th>
<th>≤ 1 Minimal</th>
<th>2 Limited</th>
<th>Multiple</th>
<th>≥ 4 Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Highest Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>B</td>
<td>Amount and complexity of data</td>
<td>≤ 1 Minimal or low</td>
<td>2 Limited</td>
<td>Multiple</td>
<td>≥ 4 Extensive</td>
</tr>
<tr>
<td>C</td>
<td>Type of decision making</td>
<td>STRAIGHT-FORWARD</td>
<td>LOW COMPLEX</td>
<td>MODERATE COMPLEX</td>
<td>HIGH COMPLEX</td>
</tr>
</tbody>
</table>
Established patient with symptomatic problem:
Assessment and Plan:

1) **Sciatica right side:** somatic dysfunction lumbar region, not resolving, OMT to reduce pain and spasms and improve function.

- History is expanded problem focused: chief complaint, 1-3 HPI elements, 1 ROS.
- Exam is expanded problem focused or detailed.
Medical Decision-Making
The cognitive labor required for the clinical example satisfies the requirements for Low Complexity Medical Decision-Making. Low Complexity Medical Decision-Making requires **TWO** out of **THREE** of the following:

- **Requires:**
  - Two Problem Points → 2 points for one problem, not resolving = low
  - Two Data Points → (0 points)
  - Table of Risk → Moderate (1 problem with mild exacerbation)

- Although the table of risk falls into moderate, the other 2 MDM tables do not meet moderate complexity (need at least 1 more moderate)
Established patient with multiple problems:

− 1) **Neck pain/stiffness:** somatic dysfunction of cervical region still present, OMT to reduce pain and improve function

− 2) **Sciatica right side:** somatic dysfunction lumber region, not resolving, OMT to reduce pain and spasms and improve function.

| Number Dx/Management options | 4 points (2 problems not resolving) |
| Data | 0 |
| Table of Risk | Moderate (mild progression) |

**History Detailed and/ or Exam Detailed**

- 4HPI
- 2-9 ROS
- 1 history
Established patient with stable problem:

- 1) **Cervical strain**: improving (1)

- Number Dx/Management options → 1 point (SF complexity)
- Data → none
- Table of Risk → Low (1 stable problem)

**History or Exam only needs to be PF, MDM straightforward**
### Outpatient Evaluation & Management

#### CPT Code Criteria

<table>
<thead>
<tr>
<th>New Patient</th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. time (mins)</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>45</td>
<td>60</td>
</tr>
<tr>
<td>Required all three key components</td>
<td>CC: Required</td>
<td>CC: Required</td>
<td>CC: Required</td>
<td>CC: Required</td>
<td>CC: Required</td>
</tr>
<tr>
<td></td>
<td>HPI: 1-3</td>
<td>HPI: 1-3</td>
<td>HPI: 4+</td>
<td>HPI: 4+</td>
<td>HPI: 4+</td>
</tr>
<tr>
<td></td>
<td>ROS: None</td>
<td>ROS: 1 Pertinent</td>
<td>ROS: 2-9</td>
<td>ROS: 10+</td>
<td>ROS: 10+</td>
</tr>
<tr>
<td></td>
<td>PFSH: None</td>
<td>PFSH: None</td>
<td>PFSH: 1</td>
<td>PFSH: 3</td>
<td>PFSH: 3</td>
</tr>
<tr>
<td></td>
<td>Exam: <strong>PF</strong></td>
<td>Exam: <strong>EPF</strong></td>
<td>Exam: <strong>Detailed</strong></td>
<td>Exam: <strong>Comprehensive</strong></td>
<td>Exam: <strong>Comprehensive</strong></td>
</tr>
<tr>
<td></td>
<td>MDM: Straightforward</td>
<td>MDM: Straightforward</td>
<td>MDM: Low</td>
<td>MDM: Moderate</td>
<td>MDM: High</td>
</tr>
</tbody>
</table>
## Outpatient Evaluation & Management CPT Code Criteria

<table>
<thead>
<tr>
<th>Established Patient</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. time (mins)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Requires two of the three key components</td>
<td>CC: Required</td>
<td>CC: Required</td>
<td>CC: Required</td>
<td>CC: Required</td>
<td>CC: Required</td>
</tr>
<tr>
<td></td>
<td>HPI: 1-3</td>
<td>HPI: 1-3</td>
<td>HPI: 1-3</td>
<td>HPI: 4+</td>
<td>HPI: 4+</td>
</tr>
<tr>
<td></td>
<td>ROS: None</td>
<td>ROS: None</td>
<td>ROS: 1</td>
<td>ROS: 2-9</td>
<td>ROS: 10+</td>
</tr>
<tr>
<td></td>
<td>PFSH: None</td>
<td>PFSH: None</td>
<td>PFSH: 1</td>
<td>PFSH: 1</td>
<td>PFSH: 2-3</td>
</tr>
<tr>
<td>Exam: None</td>
<td>Exam: PF</td>
<td>Exam: EPF</td>
<td>Exam: Detailed</td>
<td>Exam: Comprehensive</td>
<td></td>
</tr>
<tr>
<td>MDM: na</td>
<td>MDM: Straightforward</td>
<td>MDM: Low</td>
<td>MDM: Moderate</td>
<td>MDM: High</td>
<td></td>
</tr>
</tbody>
</table>
Because OMT is considered a procedure, this requires a separate procedure note. The procedure note should detail the regions manipulated, the techniques utilized, and a description of how the patient tolerated the treatment.

All regions of somatic dysfunction should be documented using “TART” terminology—Tissue texture changes, positional Asymmetry, Range of motion alterations, or changes in palpatory sensitivity (e.g., Tenderness). • Somatic dysfunction or other diagnosis should be clearly documented in the “objective findings” of the musculoskeletal examination section.
Separate the OMT procedure from EXAM

Omt and percussion
detailed physical exam of musculoskeletal system:

head: sidebent rt, rotated left at OA treated with MR to C4 also to open the sinuses (full right maxillary sinus - recurrent, persistent)
SUBOCCIPITAL fascia tight, treated with Balanced membranous TENSION RELEASE
NECK AND cspine: paraspinals are taught, acutely spasmotic, bones: C2 sidebent left, rotated left treated with:
MR/ME/HVLA
abdomen w tight fascia moves easier to the left, tx w MR
Lumbar sacral junction left piriformis somatic dysfunction tx'd w ME + MR
thoracic paraspinals tight, treated with direct roll "Chicago roll" released his right psoas dysfunction
SACRUM with ILA inferior/superior right, sulcus deep on the right/left
treated with ME/direct inferior release
PELVIS with tight soft tissues, treated with rolling DR
UE tight interosseous membrane left and right, treated with DR
bilateral restricted HAMSTRINGS left > right treated with ME

# regions: 9

general: patient is alert, oriented, well groomed
neuro: grossly normal with stable, unaided gait
skin: warm and dry

home exercises: none today
percussion hammer 'beltsander' massager x 15 min. see detailed notes assoc w dxs.
Example Separate Procedure Note

Procedure Documentation

OMT:
The patient consented to the application of OMT and was positioned appropriately for the technique(s) and repositioned as needed. Appropriate hand positioning for provision and monitoring of the techniques applied was performed. Reassessment of the effectiveness of the technique(s) used was performed.

The following OMT technique(s) was/were applied to the following areas:
Articulatory/LVHA: lumbar, sacrum, pelvis
Balanced Ligamentous Tension: sacrum, pelvis, lower extremity
Bioelectric Fascial Activation and Release: cervical, thoracic, lumbar, sacrum, pelvis, lower extremity
Chapman:
Cranial:
FPR: cervical
Fulford Percussion:
Functional: thoracic, lumbar
HVLA:
Lymph:
ME: lumbar, sacrum, pelvis, lower extremity
MFR:
PINS:
Soft Tissue: cervical, thoracic, lumbar
Still:
Strain-Counterstrain:
Visceral:

The patient tolerated the procedure well and was given post procedure instructions including stretches, resume normal activities. They are to call with any concerns or problems.
THREE (3) ADDITIONAL COMPONENTS

Counseling
Coordination of Care
Time

These components are considered contributory factors in the majority of encounters. However, counseling and coordination of care may not be provided at every patient encounter.
A discussion with a patient or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies
- prognosis
- risks and benefits of management (treatment) options
- instructions for management (treatment) or follow up
- importance of compliance with chosen management (treatment) options
- risk factor reduction
- patient and family education
The E/M guidelines do have a specific provision to allow physicians to use TIME as the controlling factor to determine the E/M level of care when counseling and/or coordination of care equals more than 50% of the encounter, using the typical time assigned to a given E/M code.

In these instances, the physician MUST spend the entire allotted time face-to-face with the patient AND more than HALF of that time must be used for “counseling and coordination of care.”

Record the duration of the face-to-face time in the record, AND also state that over half the time was spent on counseling and coordination of care. In addition, the nature of the counseling and coordination of care must be documented.
**Document:**

- Total face-to-face Physician/Provider time with the patient *(not an estimate, be specific)*.
- That more than 50% of the visit was spent counseling
- Content of the counseling in sufficient detail

**Example:**

- Total face-to-face time = 40 minutes; more than 50% spent counseling on treatment options xxx relating to diagnosis of ...........
- CPT code =99215 (typical time of this code is 40 minutes)
- The time must meet or exceed the specific CPT code assigned and should not be “rounded” to the next higher level.
## OMT procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>OMT Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>98925</td>
<td>Osteopathic manipulative treatment (OMT); 1–2 body regions involved</td>
</tr>
<tr>
<td>98926</td>
<td>Osteopathic manipulative treatment (OMT); 3–4 body regions involved</td>
</tr>
<tr>
<td>98927</td>
<td>Osteopathic manipulative treatment (OMT); 5–6 body regions involved</td>
</tr>
<tr>
<td>98928</td>
<td>Osteopathic manipulative treatment (OMT); 7–8 body regions involved</td>
</tr>
<tr>
<td>98929</td>
<td>Osteopathic manipulative treatment (OMT); 9–10 body regions involved</td>
</tr>
</tbody>
</table>

* The 10 body regions referred to are head region, cervical region, thoracic region, lumbar region, sacral region, pelvic region, lower extremities, upper extremities, rib cage region, and abdomen and viscera region.
Body regions referred to are:

- Head region
- Cervical region
- Thoracic region
- Lumbar region
- Sacral region
- Pelvic region
- Lower extremities
- Upper extremities
- Rib cage region
- Abdomen and viscera region
OMT treatments are not reported based on time.

A given treatment may require manipulation or separate techniques that are performed in several body regions. For example, OMT of the right shoulder, the right sacroiliac joint (SIJ), the left shoulder, and the left SIJ may all be performed in a single session.

Based on this example, the OMT services would be reported with code 98925, Osteopathic manipulative treatment (OMT); 1-2 body regions involved, because the upper extremities are collectively considered a single region and the bilateral SIJs is considered a second body region. While the right and left SIJ may represent two separate areas, they are both located within the sacral region.
OMT procedure codes should be reported based on the number of body regions involved that were treated. The medical record documentation should clearly note the body regions treated, which would justify the procedure code billed. Do not list the regions as ICD10 codes. A written diagnostic statement should be documented for each condition. It is not appropriate to select a code number from a list of codes in place of a written diagnostic statement.

Only one OMT service should be billed per day, based on the description of the procedure code.

Factors that may affect frequency and duration of treatment are: severity of illness, duration or chronicity of the patient’s condition and the presence of co-morbidities. These factors should be reflected in the medical record if they contribute to the physician’s treatment approach.
Example OMT

CPT CODE 98926

OMT; Three to Four Body Regions Involved

Rectangular Snip

VIGNETTE
A 39-year-old female presents with right lower back pain of two weeks duration after a lifting injury. Somatic dysfunction of lumbar, pelvis, and sacral regions are identified on exam.

DESCRIPTION OF PRESERVICE WORK
The physician determines which osteopathic techniques (e.g., HVLA, muscle energy, counterstrain, articulatory) would be most appropriate for this patient, in what order the affected body regions need to be treated, and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.
DESCRIPTION OF **INTRASERVICE WORK**
The patient is initially in the prone position on the treatment table. Motion restrictions of sacrum and pelvis are isolated through palpation and treated using muscle energy and articulatory techniques. Dysfunctions of L1 and L5 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

DESCRIPTION OF **POSTSERVICE WORK**
Postcare instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.
ICD-10: Expand documentation to include:

• Laterality (left vs. right, or bilateral)
  - Over 1/3 of the expansion of ICD-10 codes is due to the addition of laterality

• Anatomic details (for example, fractures)

• Complications > broken rod s/p fusion = T84.216A
  (breakdown (mechanical) of internal fixation device of vertebrae, initial encounter)

• Code all documented conditions that coexist at the time of the visit and require or affect patient care treatment or management (co-morbidities)

• Do not select codes from the problem list if not addressed in the visit. Only link ICD10 codes that are relevant to the visit.
ICD10 codes that support medical necessity for OMT

- M99.00 Segmental and somatic dysfunction of head region
- M99.01 Segmental and somatic dysfunction of cervical region
- M99.02 Segmental and somatic dysfunction of thoracic region
- M99.03 Segmental and somatic dysfunction of lumbar region
- M99.04 Segmental and somatic dysfunction of sacral region
- M99.05 Segmental and somatic dysfunction of pelvic region
- M99.06 Segmental and somatic dysfunction of lower extremity
- M99.07 Segmental and somatic dysfunction of upper extremities
- M99.08 Segmental and somatic dysfunction of rib cage
- M99.09 Segmental and somatic dysfunction of abdomen and other regions
Cloning

- NGS has specific policies on information in the medical record documentation that is cloned and or brought forward from previous encounters.
- For example, when all PFSH/ROS on the notes are worded exactly like previous entries. Specific information regarding ROS should be unique for each patient encounter. It is permissible to document the review of PFSH form an earlier date.
- Many records had lab and radiology historical data brought forward on each date of service. It is difficult for a reviewer to identify what was reviewed and not reviewed on a particular date of service in order to give credit.
- On many notes, with the exception of the vitals and OMT assessment, the exams appeared the same as the previous DOS. Again, each exam should be unique for that date of service.
Thank-you!

QUESTIONS?