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Narrative Review

Compliance And Documentation for Evaluation and Management Services in Interventional Pain Management Practice

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Evaluation of new and established patients is an integral part of interventional pain management. Over the last 3 decades, there has been significant confusion over the proper documentation for evaluation and management (E/M) services in general and for interventional pain management in particular. Interventional pain physicians have learned how to evaluate patients presenting with pain on the basis of their specialty training. Although modern training programs are introducing residents and fellows to the intricacies of E/M services and federal regulations, this has not always been the case. Multiple textbooks about pain management, physiatry, and neurology, and numerous journal articles have described the evaluation of pain patients, but they have not been specific to chronic pain patients and may not meet the regulatory perspective.

A multitude of these issues led to the development of guidelines in 1995 and 1997, which were highly complicated and difficult to follow. These also led to significant criticism from clinicians. Consequently, further guidance was developed to be effective January 2021.

The crucial concept in the present system of coding for E/M services is medical decision making, which includes 3 elements since 2021:

1. The number and complexity of problems addressed
2. Amount or complexity of data to be reviewed and analyzed
3. Risk of complications and/or morbidity or mortality of patient management

In order to select a level of E/M service, 2 of the 3 elements of medical decision making (MDM) must be met or exceeded. This is in contrast to prior guidelines wherein for new patients, all 3 elements with history, physical examination and MDM , and for established patients have been met. For ease of appreciation, an algorithmic approach created by the American Medical Association (AMA), and Centers for Medicare and Medicaid Services (CMS) approved a new MDM table outlining all of the appropriate criteria.

This review systematically describes the changes and provides an algorithmic approach for application in interventional pain management practices.

Key words: Evaluation and management services, new patient, established patient, level of service, CPT coding, medical decision making, complexity of problems

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"It is as important to know the person who has the disease as to know the disease the person has."

- Sir William Osler

The medical evaluation of patients has been a fact of life since the beginnings of medical history (1-10). Over the years, advances in medicine and increasing knowledge and understanding of the physiologic concepts of pain have dramatically improved the evaluation process. Although medicine was always influenced by federal regulations, the influence of these laws and regulations has become much more intrusive since the enactment of Medicare and continuing regulations and fee schedules (11-17). The evolution of numerous regulations governing the practice of medicine by the Centers for Medicare & Medicaid Services (CMS) began in the 1990s with the implementation of E/M guidelines (12-21). The official guidelines in the United States were developed in 1995 and 1997 (18,19).

- During the years prior to 1996:
- Physicians followed a simple format characterized by an acronym, SOAP, which stands for Subjective, Objective, Assessment, and Plan.
- SOAP was later expanded, presumably to meet the criteria of CMS's E/M services, to SOAPER to also include Education and Return instructions.
- Another variation of the same theme included SOAPIE, which is an abbreviation for Subjective, Objective, Assessment, Plan, Intervention, and Evaluation.
- A final expanded format was SNOCAMP, standing for Subjective, Nature of presenting problem, Counseling, Assessment, Medical Decision-Making, and Plan.

Owing to the complicated nature of the documentation guidelines proposed by the CMS, SOAP, SOAPER, SOAPIE, and SNOCAMP failed to meet the criteria in most cases, even before 1995. Other variations are as complicated as CMS guidelines. The CMS and multiple specialty societies continue to struggle with differing opinions, in favor of and against the various components of E/M guidelines.

- Due to overwhelming complaints from physicians and lack of compliance with CMS guidelines, Medicare initially proposed in 2019 a fee schedule, which was released in July 2018, with simplification of the code level selection and removal of unnecessary history and examination elements.
- Simplification included elimination of payment differentials between services. This essentially condensed the visit payment codes into 2 levels with 99201 and 99202; and 99211 and 99212.
- The medical organizations were concerned about this coding and over 170 organizations provided comment letters. In summary, physicians were extremely frustrated by "note bloat".

Following the above advocacy efforts, a CPT-RUC Work Group was formed with guiding principles to reduce the burden by various actions.

The 2021 guidelines were the product of the CPT-RUC committees, and they were subsequently adopted by CMS.

These guidelines also changed on multiple occasions each year with publication of a physician fee schedule and the change in the administration (18-29). These guidelines were too complex to be followed appropriately with multiple components of services for each level of service with elements and bullets plus increased levels of audits leading overall to increased burnout and stress among clinicians.

In 2016 and 2017, these issues were brought to the attention of CMS by the American Medical Association (AMA) and multiple component societies. Subsequently, a simplification was published in July 2018 (30,31). The goal was administrative simplification and perception of CMS that the E/M codes at the time were outdated based on past comment letters. These initial proposals (30,31) sought to simplify code level selection and remove unnecessary history and examination elements. Physicians also had a choice of method of documentation utilizing either CMS 1995 or 1997 documentation guidelines, medical decision making (MDM) only or face-to-face time. Further, simplification included elimination of payment differential between services.

The collapsing of the services resulted in only 2 codes with Current Procedural Terminology (CPT) 99201 and 99211 and CPT 99202 and 99212 instead of 10 codes. To avoid the impact on specialties as a whole, they also proposed specialty add-on code and prolonged services add-on .

However, this rule created major concerns and a comment letter was written by 170 organizations opposing this change, even though they applauded the concept of simplification.

Subsequently, AMA formed a CPT-RUC Work Group with CPT and RVS Update Committee (RUC) members on the committee. This committee was charged with capitalization on the CMS proposal with solicitation of suggestions and feedback on the best coding structure to foster burden reduction, while ensuing appropriate evaluation. They were also charged with providing a quick response to present to CMS with a tangible alternative to the 2018 proposal. The Work Group functioned with a guiding principle of reducing the burden and simplification, thus resulting in major E/M services revisions for 2021 for office or other outpatient services (30,32,33).

- Prior to 2021, history and examination were 2 of the 3 components, along with medical decision making, used to select the appropriate E/M services.
- Since January 2, 2021, history and examination were no longer used to select an E/M service, but a "medically appropriate history or examination" must be performed in order to report CPT codes 99202 to 99215 for various levels.
- Consequently, the new system E/M code selection was based on either the level of MDM or the time spent performing the service on the day of the encounter.
- Effective January 2, 2021, a prolonged service code was created to describe a prolonged office and outpatient E/M service of 15 minutes beyond the total time of the primary E/M procedure for either CPT codes 99205 or 99215.
- In 2023, the prolonged codes have been expanded (30-38).

Components Of E/M Services

Levels of Service

- E/M services in interventional pain management are office and hospital outpatient services (30-39). These include four levels for new patients and 5 levels for established patients to include 99202 to 99205 and 99211 to 99215 as shown in Table 1.
    - Level 1. Problem-focused
    - Level 2. Expanded problem-focused
    - Level 3. Detailed/low complexity
    - Level 4. Comprehensive/moderate complexity
    - Level 5. Comprehensive/high complexity.
- To determine the appropriate level of service for a patient's visit, it is necessary to first determine whether the patient is new or established. The physician then uses the MDM as a guiding factor in his or her clinical judgement about the patient's condition to determine the level of service. The key elements of service include MDM or time.

Time

- The definition of time in 2021 has significantly changed.
- The definition of time associated with CPT codes 99202 to 99215 has been revised from the typical face-to-face time to a total physician or qualified health care professional (QHP) time spent on the day of the encounter (30).
- Time may be used to select a code level whether or not counseling and/or coordination of care dominates the visit.
    - The routine documentation that counseling and coordination of care constituting 50% of the time is not only unnecessary but could turn out to be detrimental. Consequently, documentation of counseling and/or coordination of care is not required.
- Time includes both face-to-face and non-face-to-face activities performed by the physician or QHP.
- Multiple activities included in the time also have been expanded in contrast to prior guidance where only the face-to-face time was counted towards the service.
    - Preparing to see the patient, including review of the tests, the reports, and the chart.
    - Obtaining and/or reviewing separately obtained history.
    - Ordering medications, tests, and procedures.
    - Referring and communicating with other healthcare professionals when not separately reported.

Table 1. *Categories and subcategories of levels of service.*

i. New Patient
99202 – Expanded-Problem-Focused, Straightforward
99203 – Detailed, Low Complexity
99204 – Comprehensive, Moderate Complexity
99205 – Comprehensive, High Complexity
ii. Established Patient
99211 – Brief
99212 – Problem-Focused, Straightforward
99213 – Expanded-Problem-Focused, Low Complexity
99214 – Detailed, Moderate Complexity
99215 – Comprehensive, High Complexity

- Documenting clinical information in the electronic or other health record.
- Independently interpreting the results (not separately reported) and communicating results to the patient/family
- Caregiver/care coordination not separately reported.

- Clinical staff (staff working under the supervision of a physician or QHP within the state laws and scope of practice) activities on a service may NOT be included in the calculation of total time for the purposes of code selection (Table 2).
- The total time corresponding to CPT® codes 99202-99215 (except for 99211) have been clearly defined as specific intervals effective January 1, 2021.
- There are variations in time as the present codes clearly define specific intervals compared to older versions where it generally stated criteria based on typical minutes spent on the date of the encounter.
- Split/shared visit is defined as when the physician and QHP each perform the face-to-face and non-face-to-face work for a visit, the time spent by each is summarized for the total time.

Table 3 shows review of time factor prior to 2021 and after January 1, 2021, with included changes to arrive at level of coding.

Table 2. *Total time in determining level of service since 2021.*

New Patient		Established Patient	
Code	**Time**	**Code**	**Time**
		99211	NA
99202	15-29 min	99212	10-19 min
99203	30-44 min	99213	20-29 min
99204	45-59 min	99214	30-39 min
99205	60-74 min	99215	40-54 min

Table 3. *Review of the changes before and after January 2021.*

Prior to January 1st, 2021	After January 1st, 2021
Time may only be used/selected if 50% of the encounter is spent on counseling and/or coordination of care.	Time can be used to select an E&M code whether or not counseling and/or coordination of care dominates the visit.
Time is based on only face to face activities on the date of service.	Time includes both face to face and non-face to face activities on the date of service
Time criteria is based on a typical time for the level of service.	Time is based on defined intervals of time.

Medical Decision Making

The crucial concept in the present system of coding for E/M services is medical decision making, which includes 3 elements since 2021:

1. The number and complexity of problem(s) addressed.
2. Amount and/or complexity of data to be reviewed and analyzed.
3. Risk of complications and/or morbidity or mortality of patient management.

The levels of MDM are shown in Table 4.

Selecting the Appropriate Code in Medical Decision Making

In order to select a level of E/M service, 2 of the 3 elements of MDM must be met or exceeded.

- This is in contrast to the prior guidelines wherein for new patients, all 3 elements (history, physical examination, and MDM) and 2 of the 3 for established patients must have been met.
- AMA has created and CMS approved a new MDM table which further outlines the criteria for E/M code level selection. As always, documentation should support the E/M code selected (Table 5).
- As shown in Table 5, there are 3 columns describing the number and complexity of problems addressed, amount and/or complexity of data to be reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management for all levels from low to high (99203/20213 to 99205/99215).
  - Amount and complexity of data to be reviewed and analyzed is described in 3 categories.
  - Risk of complications and morbidity or mortality of patient management are shown as minimal risk of morbidity, low risk of morbidity, moderate risk of morbidity or high risk of morbidity from additional diagnostic testing or treatment.
- MDM terms and definitions are shown in Tables 6 and 7.

Table 4. *Levels of medical decision making (MDM).*

New Patient		Established Patient	
Code		**Code**	
99202	Straightforward	99212	Straightforward
99203	Low level	99213	Low level
99204	Moderate	99214	Moderate
99205	High level	99215	High level

- Table 6 shows various terms, including minimal problems; self-limited or minor problem; stable, chronic illness; acute, uncomplicated illness or injury; and acute, complicated injury.
- Table 7 shows terms and definitions of acute or chronic illness with or without exacerbation, undiagnosed new problems, and acute illness with systemic symptoms.

Selecting a Code Based Medical Decision Making

In selecting a code, multiple steps must be followed in an algorithmic fashion.

- Step 1: Select the applicable number and complexity of problem(s) addressed at the encounter.
- Step 2: Select the amount and/or complexity of data to be reviewed and analyzed.
- Step 3: Select the risk of complications and/or morbidity or mortality of patient management.

Table 5. *Level of medical decision making (MDM) for various levels of service.*

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number of Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Morality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of mobidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Chronic low back pain • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (must meet the requirements of at least 1 out of 3 categories) Category 1 : Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of managment or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of mobidity from additional diagnostic testing or treatment. Examples only: • Prescription drug mangement • Decision regarding minor surgery with identified patient or procedure risk factors •Diagnosis or treatment significantly limited by social determinants of health

Table 5 cont. *Level of medical decision making (MDM) for various levels of service.*

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number of Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Morality of Patient Management
99205 99215	High	High • 1 or more chronic illnesses with severe illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

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- Step 4: Put the selections together to determine the appropriate E&M code selection and level.

Prolonged Services

In 2021, a single prolonged service code was developed to show 15 minutes beyond the total time of primary E/M procedure after Level 5 (30-39). However, this code can only be reported based on time, not medical decision making. In 2023, new codes have been developed wherein prolonged service can be reported with or without patient contact, face-to-face, or non-face-to-face time on the date of an office or other outpatient service. It is a smaller time increment (15 minutes) than current prolonged 2021 services codes which cannot be reported if the service is less than 30 minutes. Table 8 describes the prolonged services.

Appropriate Documentation And Establishing Medical Necessity

History

The history includes:

- Chief complaint
- History of present illness
- Review of systems
- Past, family, and/or social history.

The extent of history obtained and documented depends on the clinical judgment of the physician and the nature of the MDM relevant to the problem. Nevertheless, the required documentation is progressively detailed and complex based on the level of complexity:

99202 Straightforward
99203 Low level

99204 Moderate
99205 High level

Chief Complaint

The chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician-recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words. This should be clearly documented in the medical record. The chief complaint should always be the first thing in the initial evaluation, history and physical, and progress note.

History of Present Illness

History of present illness is a chronological descrip-

Table 6. *Medical decision-making (MDM): Terms and definitions I.*

Term	Definition
Minimal problem	A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (CPT 99211).
Self-limited or minor problem	A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.
Stable, chronic illness	A problem with an expected duration of at least a year or until the death of the patient.
Acute, uncomplicated illness or injury	A recent or new short-term problem with low risk of morbidity for which treatment is considered.
Acute, complicated injury	An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Table 7. *Medical decision-making (MDM): Additional terms and definitions II.*

Term	Definition
Chronic illness with severe exacerbation, progression, or side effects of treatment	The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.
Acute or chronic illness or injury that poses a threat to life or bodily function	An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.
Chronic illness with exacerbation, progression, or side effects of treatment	A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.
Undiagnosed new problem with uncertain prognosis	A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.
Acute illness with systemic symptoms	An illness that causes systemic symptoms and has a high risk of morbidity without treatment.

Table 8. *Revised and/or prolonged service codes for 2023.*

Deleted Codes (Effective 2023)	Existing Code and Descriptor		Revised Code Descriptor (Effective Jan 1, 2023)
99354 and 99355 (Prolonged services on the date of an outpatient service)	99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact, beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	Prolonged office or other outpatient evaluation and management service(s) time with or without direct patient contact beyond the minimum required time of the primary service procedures which when the primary service level has been selected using total time, requiring total time with or without direct patient contact, beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)
99356 and 99357 (Prolonged services on the date of an inpatient or observation or nursing facility service)	99418	N/A	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service, when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management services)

Source: American Medical Association. CPT E/M Companion 2023.

tion of the development of the patient's present illness from the first sign or symptom or from the previous encounter to the present. It includes the following elements:

- Location: Describing the area of the body (neck, low back, head, abdomen, etc.).
- Quality: Characteristic of chief complaint — pain character (deep, throbbing, cramping, aching, sharp, shooting, etc.).
- Severity: Satisfied by pain-rating scale, either visual analog, verbal, or numerical scale describing the level of pain.
- Duration: Symptom duration from onset to the present encounter.
- Timing: Description of the pain pattern — continuous, intermittent, in the evening or afternoon, etc.
- Context: Specific circumstances, conditions, and activities surrounding the present condition.
- Modifying factors: Measures taken to relieve symptoms or discomfort, such as physical therapy, surgery, injection therapy, drug therapy, and the like, and results with these measures.
- Associated signs and symptoms: Numbness, weakness, blurred vision, disturbed sleep pattern, difficulty with activities of daily living, etc.

Brief and extended histories of the present illness are distinguished by the amount of detail needed to characterize the clinical problem accurately. A straightforward and low-level history of the present illness requires documentation of one to 3 elements of the present illness, whereas moderate and high levels of history of present illness requires documentation of at least 4 elements of the history of the present illness.

Review of Systems

Review of systems is an inventory of body systems obtained through a series of questions seeking to identify signs or symptoms (or both) that the patient may be experiencing or has experienced relevant to medical decision making.

Past, Family, and Social History

The past, family, and social history relevant to MDM is required.

- A review of a patient's history including experiences, illnesses, operations, injuries, and treatments.
- Family history, including a review of medical events in the patient's family, hereditary diseases, and other factors.
- Social history should be appropriate for age reflecting past and current activities.

Physical Examination

The type and extent of physical examination is dependent on medical decision making.

The requirements prior to 2021 are no longer applicable. However, a physical examination is essential to meet the criteria of medical decision making. The elements and bullets have been eliminated.

Medical Decision Making

Documentation of the complexity of MDM involves 4 types of MDM to accommodate all levels of E/M services (30-39). The 4 types of MDM options include:

- Straightforward (CPT 99202, 99212)
- Low (CPT 99203, 99213)
- Moderate (CPT 99204, 99214)
- High (CPT 99205, 99215)
- The most significant changes include:
    - MDM has always been part of the algorithm for choosing a level of service but will now be the sole determinant of level of service (unless the provider intends to bill based on time).
    - From 2021, MDM is based on:
        - Number and complexity of problem(s) addressed.
            - * Including status (e.g., uncomplicated, exacerbation) and timeline (e.g., acute, chronic)
        - Amount and/or complexity of data reviewed and analyzed
            - * This category attempts to quantify the amount of data, efforts to gather data, and communications utilized to evaluate a patient. Collection of more data leads to a higher level of MDM.
        - Risk of complications and/or morbidity or mortality.

Selecting a Level of Service

Effective January 1, 2021, the appropriate level of service for office or other outpatient E/M services is based on the following:

- The level of the MDM as defined for each service.
    - Number and complexity of problem(s) addressed at the encounter
    - Amount and/or complexity of data to be reviewed and analyzed

- Risk of complications and/or morbidity or mortality of patient management or
- The total time on the date of the encounter
- Includes total time on the date of the encounter
- May be used to select a code level whether or not a counseling and/or coordination of care dominates the service
- Includes physician/other qualified health professional (QHP) face-to-face and non-face-to-face time
- Count only one person per minute when more than one clinician is addressed.

The activities involved in total time for physicians and QHP are shown in Table 9.

Table 9. *Total time: Physicians and QHP.*

Physician/other QHP time includes the following activities (when performed):
• Preparing to see the patient (e.g., review of tests)
• Obtaining and/or reviewing separately obtained history
• Performing a medically necessary appropriate examination and/or evaluation
• Counseling and educating the patient/family/caregiver
• Ordering medications, tests, or procedures
• Referring and communicating with other health care professionals (when not reported separately)
• Documenting clinical information in the electronic or other health record
• Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
• Care coordination (not reported separately)
DO NOT COUNT time spent on separately reported services

Number and Complexity of the Problem(s)

One element in the level of code selection for an office or other outpatient service is the number and complexity of the problem(s) that are addressed at an encounter.

- Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.
  - Low back and leg pain
  - Neck pain with headache and arm pain

Noting chronic conditions that another specialist manages in the patient's medical record does not alone qualify as being problem-addressed (36).

Conditions: Acute, Uncomplicated, Stable Or Chronic Illness

Acute Uncomplicated Illness or Injury

A recent or new short-term problem with low risk of morbidity for which treatment is considered.

- There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.
- A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include:
  - Cervical, lumbar strain
  - Twisting of ankle.

Stable Chronic Illness

- Conditions are treated as chronic whether or not stage or severity changes
  - Controlled or uncontrolled pain condition
    - Chronic low back pain
    - Chronic neck pain
- Stable
  - Defined by the specific treatment goals for an individual patient
  - Not at treatment goal is not stable, if the condition does not change
  - The risk of morbidity (return of pain and dysfunction without treatment is crucial)

MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

MDM Risk

AMA defines risk as:

- The probability and/or consequences of an event.
- The assessment of the level of risk is affected by the nature of the event under consideration.
- The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.
  - A low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.
- For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
- Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or hospitalization.

- It's a major or minor risk and not a major or minor procedure.
  - The provider needs to assess and clearly document the patient's individual risk factors along with the procedure's risk factors to determine the overall risk.
  - The risk determination is also based upon the "usual behavior" of a physician or QHP within that specialty.

MDM Risk of Complications and/or Morbidity or Mortality of Patient Management

- Straightforward
  - Minimal risk from treatment (including no treatment) or testing (most would consider this effectively as no risk).
- Low
  - Low risk (i.e., very low risk of anything bad), minimal consent/discussion
- Moderate
  - Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management.
- High
  - Need to discuss some pretty bad things that could happen for which physician or other qualified health care professional will watch or monitor.

Prescription Drug Management

- It is essential to clarify that prescription drug management in the moderate row of the MDM chart does NOT include refills or continue current medications.
- Consequently, prescription drug management would only include increasing or decreasing a medication or adding a new medication.
- Only documenting "reviewed" on the medication list does not support prescribing drug management.
- A refill or a continued current medication without a refill being needed at that visit may or may not be considered as prescription drug management.
- Importantly:
  - Prescription drug management includes:
    - If the provider is addressing a problem that includes continuing a prescription drug (or refill) in their education and MDM to manage the diagnosis, then it may be included in prescription drug management.
    - The provider may choose to use qualifying factors of total time when choosing the E/M level of service.

Identification of MDM in Interventional Pain Management

- Straightforward (CPT 99202, 99212) as shown in Table 10.
  - One self-limited or minor problem (cervical strain, shoulder strain, lumbar strain)
  - Minimal or no diagnostic procedures ordered
  - Risk of complications and/or morbidity or mortality of patient management
    - Minimal risk of morbidity from additional diagnostic testing or treatment
- Low (CPT 99203, 99213) as shown in Table 10.
  - 2 or more self-limited or minor problems, or one stable chronic illness, or one acute, uncomplicated illness or injury
  - 2 minor problems or one acute, uncomplicated illness or injury (cervical strain, lumbar strain, knee strain, shoulder strain)
  - One stable chronic illness (chronic low back pain, chronic neck pain, chronic hip pain)
  - Amount and/or complexity of data to be reviewed and analyzed This includes meeting of at least one out of the 2 criteria from the following categories.
    - Category 1: Tests and documents or
    - Assessment requiring an independent historian(s)
  - Risk of complications and/or morbidity or mortality of patient management
    - Low risk of morbidity from additional diagnostic testing or treatment:
      - Exercise program
      - Physical therapy
      - NSAIDs
      - Ordering X-rays
      - Referral
- Moderate (CPT 99204, 99214) as shown in Table 11.
  - One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment:
    - Chronic low back pain with exacerbation or worsening, or
    - 2 or more stable chronic illnesses (chronic low back pain, chronic neck pain, chronic chest wall pain), or
    - One undiagnosed new problem with

Table 10. *Elements of medical decision making (MDM) for Level 2 and 3 or straightforward or low complexity services.*

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem • Cervical strain • Shoulder strain • Lumbar strain	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems, or one stable chronic illness, or one acute, uncomplicated illness or injury or • 2 minor problems or one acute, uncomplicated illness or injury • Cervical strain • Lumbar strain • Knee strain • Shoulder strain or • 1 stable chronic illness; • Chronic low back pain • Chronic neck pain • Chronic hip pain	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment • Exercise program • Physical therapy • NSAIDs • Ordering X-Rays • Referral

Adapted and modified from:
Hollman P, Jagmin C, Levy B. Evaluation and Management (E/M) Office Visits – 2021. American Medical Association. Accessed 03/10/2023. https://www.ama-assn.org/system/files/2020-04/e-m-office-visit-changes.pdf (30).
American Medical Association. CPT Evaluation and Management (E/M) Code and Guideline Changes, effective January 1, 2023. Accessed 04/11/2023. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf (31).

uncertain prognosis (low back pain, neck pain, headache, abdominal pain), or
- One acute illness with systemic symptoms or one acute complicated injury (vertebral fracture, spinal cord injury).

- Amount and/or complexity of data to be reviewed and analyzed is somewhat complicated and difficult for interventional pain management practices to meet. This includes meeting of at least one out of the 3 criteria from the following categories.
  - Category 1: Tests, documents or independent historian(s) or
  - Category 2: Independent interpretation of tests or
  - Category 3: Discussion of management or test interpretation with external physician
  - Risk of complications and/or morbidity or mortality of patient management
    - Moderate risk of morbidity from additional diagnostic testing or treatment:
      - Prescription drug management
      - Decision regarding minor surgery with identified patient or procedure risk factors.
      - Decision regarding elective major surgery without identified patient or procedure risk factors.
      - Diagnosis or treatment significantly limited by social determinants of health.
- High (CPT 99205, 99215) as shown in Table 12.
  - One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or one acute or chronic illness or injury

Table 11. *Elements of medical decision making (MDM) for Level 4 or moderate complexity services.*

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
	Moderate	Moderate
		• 1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment;
		• Chronic low back pain with exacerbation or worsening
		or
		• 2 or more stable chronic illnesses;
		  • Chronic low back pain
		  • Chronic neck pain
		  • Chronic chest wall pain
		or
		• 1 undiagnosed new problem with uncertain prognosis
		  • Low back pain
		  • Neck pain
		  • Headache
		  • Abdominal pain
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
		  • Vertebral fracture
		  • Spinal cord injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• Any combination of 3 from the following:
			• Review of prior external note(s) from each unique source*; - ER, MD
			• Review of the result(s) of each unique test*; - Imaging, UDI
			• Ordering of each unique test*; - MRI, UDI
			• Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				  • Opioids
				  • Adherence mentoring
				  • Referral
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health
				  • Housing, transportation, income, racism, discrimination etc.

that poses a threat to life or bodily function (acute disc herniation, cauda equina syndrome, spinal cord injury, epidural abscess, discitis).

- One acute or chronic illness or injury that poses a threat to life or bodily function (spinal cord injury, epidural abscess, epidural hematoma, discitis)
- Amount and/or complexity of data to be reviewed and analyzed is difficult for interventional pain management practices to meet. Extensive data must meet the requirements of at least 2 out of the 3 criteria from the following categories.
    - Category 1: Tests, documents or independent historian(s) or
    - Category 2: Independent interpretation of tests or
    - Category 3: Discussion of management or test interpretation with external physician
- Risk of complications and/or morbidity or mortality of patient management
    - High risk of morbidity from additional diagnostic testing or treatment:
        - Drug therapy requiring intensive monitoring for toxicity
        - Decision regarding elective major surgery (SCS) with identified patient
        - Procedure risk factors, decision regarding emergency major surgery.

Table 12. *Elements of medical decision making (MDM) for Level 5 or high complexity services.*

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/ or Morbidity or Mortality of Patient Management

99205
99215
	High	High
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		  • Acute disc herniation
		  • Cauda equina syndrome
		  • Spinal cord injury
		  • Epidural abscess
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		  • Spinal cord injury
		  • Epidural abscess
		  • Epidural hematoma
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• Any combination of 3 from the following:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment:
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				  • Concurrent opioid therapy
				  • Methadone
				  • High Doses
				  • Intrathecal fusion systems
				• Decision regarding elective major surgery (SCS) with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				  • Epidural hematoma
				  • Epidural abscess
				  • Discitis
				  • Cauda equina syndrome

Tables 10 to 12 show various components of MDM from straightforward to high levels of risk.

Prolonged services code changes effective January 1, 2023, are shown in Table 13 (40).

- A new code has been created (99418) to align with the new prolonged inpatient E/M services.
- Codes 99354-99357 have been deleted.
- Code 99418 should be reported for prolonged services on the date of an inpatient, observation, or nursing facility service.
- Significant revisions have been made to the guidelines to direct users regarding the appropriate use of these codes. Codes 99358 and 99359 are still reported for prolonged services conducted on a date other than the date of the face-to-face E/M service.
- The E/M guidelines have been revised to reflect the now-uniform structure and additional clarifications or modifications pertinent to these services. It is essential to review the official E/M guidelines in full to ensure complete understanding of all the changes.

Algorithmic Approach to Documentation: E/M Services

An algorithmic approach is designed to promote the efficient use of E/M services based on the guidelines, which may not be applicable for each and every patient. The purpose of the algorithmic approach is to provide disciplined use of documentation to avoid unnecessary care, poor documentation practices, fraud, abuse, and increase compliance. Table 14 shows an algorithmic approach to documentation of E/M services which shows documentation based on symptomatology or history of present illness, which includes number

of problems and complexity, medical necessity, and risk assessment.

Documentation of Pain Scores

The most commonly utilized pain scores are based on 11-point Numeric Rating Scale (NRS) scale on scale 0-10 with 0 as no pain, 1-3 as mild, 4-6 as moderate, and 7-10 as severe. Table 15 shows NRS.

Pain relief documentation must be performed for all the patients for interventional techniques, as well as medical therapy. Table 16 shows pain relief documentation with interventional techniques and medical management; however, this may be either for interventional techniques, medical management, or combination of both.

Table 13. *Time range and starting point: Reporting prolonged clinical staff time (99415, 99416) with E/M office or other outpatient codes (99202-99205, 99211-99215).*

Office or Other Outpatient Code and Typical Clinical Staff Time (Minutes)	Prolonged Service Codes	
	99415 Time Range (Minutes)	99416 Starting Point
99202 (29)	59-103	104
99203 (34)	64-108	109
99204 (41)	71-115	116
99205 (46)	76-120	121
99211 (16)	46-90	91
99212 (24)	54-98	99
99213 (27)	57-101	102
99214 (40)	70-114	115
99215 (45)	75-119	120

Source: American Medical Association. CPT E/M Companion 2023.

Functional Status

Multiple tests have been recommended for functional disability testing. These include Oswestry Disability Index (ODI), Neck Disability Index (NDI) scored on 0-5 for each item with total scores of 50, and many others as shown in Tables 17 (41,42) and 18 (43). These instruments are essential to show that the patient has moderate to severe disability for various types of interventional techniques. A score of:

- 0-4 no disability
- 5-14 – mild disability
- 15-24 – moderate disability
- 25-34 – severe disability
- 35-50 – completely disabled.

The follow-up at each appointment with these tests may become cumbersome and time consuming. Consequently, a simpler form has been developed to show the changes from the baseline or without treatment or if the treatments were to be stopped compared to the functional status following the treatment on the date of observation or follow-up as shown in Table 19. As shown in the Table, this assessment shows

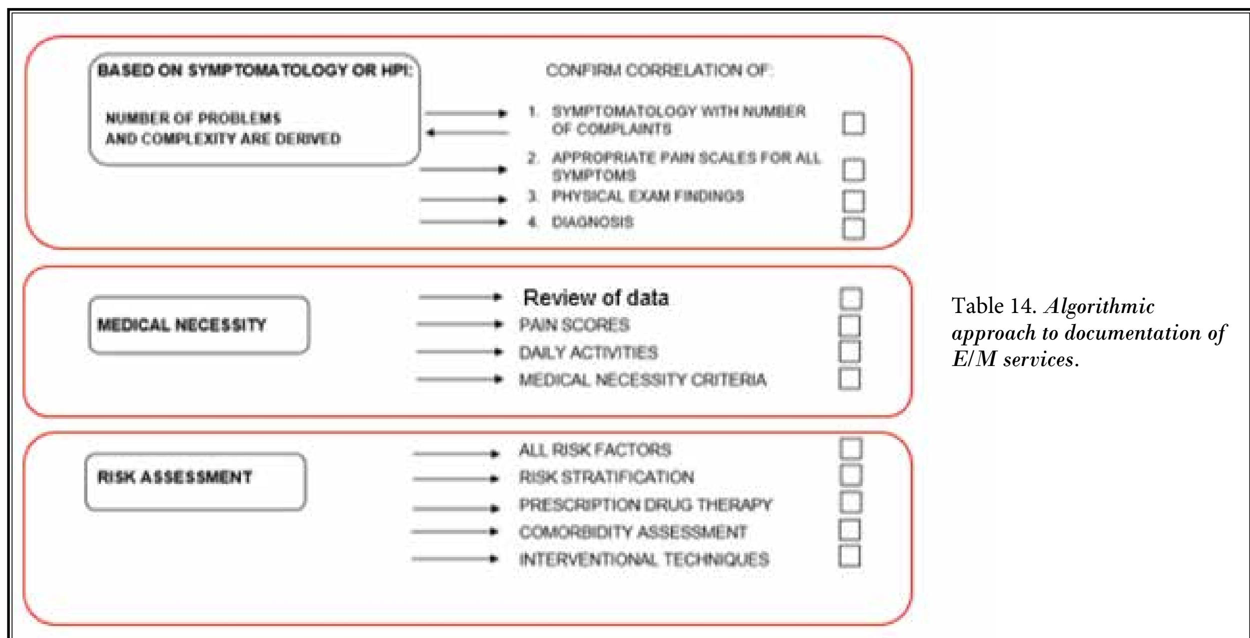

Table 14. *Algorithmic approach to documentation of E/M services.*

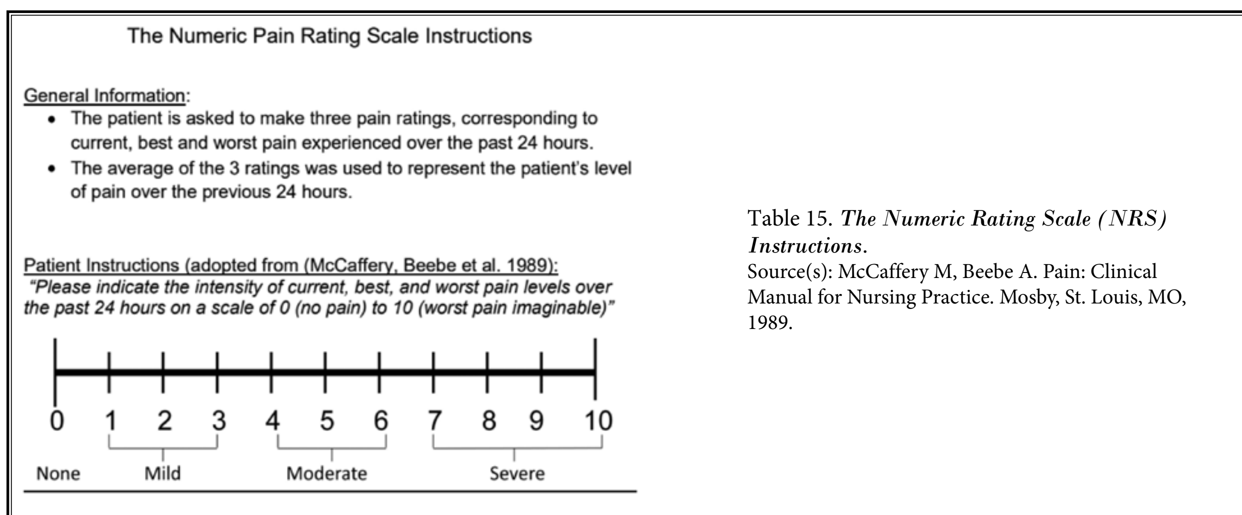

Table 15. *The Numeric Rating Scale (NRS) Instructions*.
Source(s): McCaffery M, Beebe A. Pain: Clinical Manual for Nursing Practice. Mosby, St. Louis, MO, 1989.

the information on working status, sitting, standing, walking, climbing stairs, lifting, carrying, or ability to perform overhead activities and drive.

Activities of Daily Living (ADLs)

There are various tests available again for activities of daily living (ADLs). More commonly utilized, comprehensive, and easy to administer is the KATZ Index of Independence in Activities of Daily Living, which has been validated as shown in Table 20.

Opioid Risk Assessment

A proportion of patients receiving opioids in interventional pain management settings is considered to be high ranging from a very low proportion in physiatry settings, mostly dealing with acute or subacute pain problems, whereas in patients with chronic pain problems with much longer duration of symptomatology and suffering, it may be high. As a result, assessment of opioid risk is crucial in interventional pain management settings. Screener and Opioid Assessment for Patients with Pain (SOAPP®) or a multitude of other tests are available (44-48). The most frequently recommended instruments for assessing the risk of opioid misuse before initiating long-term opioid therapy include the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) or Opioid Risk Tool (ORT). The SOAPP-R and ORT are patient self-administered instruments. In the experience of the authors, SOAPP-R is the most frequently used instrument, followed by ORT. SOAPP Version 1.0 is a quick and easy to use questionnaire designed to help providers to evaluate the patient's relative risk for developing problems when placed on long-term opioid therapy.

Table 16. *Pain relief documentation with interventional techniques*.

Pain Status
Cervical Epidural Injections:
•80% relief for 11 weeks with neck pain with cervical epidural injection on 06/15/2022 •50% relief for 1½ weeks with neck pain with cervical epidural injection on 06/15/2022
Lumbar Radiofrequency Thermoneurolysis:
•80% relief for 4 months with low back pain with lumbar radiofrequency thermoneurolysis on 02/02/2022 •60% relief for 1½ months with low back pain with lumbar radiofrequency thermoneurolysis on 02/02/2022 •50% relief for 1½ months with low back pain with lumbar radiofrequency thermoneurolysis on 02/02/2022
Medical Management:
•70% relief with medical management with knee and abdominal pain
Structured Exercise Program:
•Cervical Exercise Program – continued since 06/15/2022 •Lumbar Exercise Program – continued since 02/02/2022

Numeric Pain Score:			
	Baseline	**Average**	**Today's**
Cervical	9	3	4
Lumbar	10	4	7
Abdomen	9	3	3
Bilateral knee	8	3	3

Table 21 shows Opioid Risk Tool (ORT) (46), a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain (49,50). Based

Table 17. *Oswestry Low Back Disability Questionnaire.*

Oswestry Disability Index (ODI)

Patent Name: ________________________________

Date: ________________________________

1. Pain Intensity	
☐ I have no pain at the moment	+0
☐ The pain is very mild at the moment	+1
☐ The pain is moderate at the moment	+2
☐ The pain is fairly severe at the moment	+3
☐ The pain is very severe at the moment	+4
☐ The pain is the worst imaginable at the moment	+5

2. Personal Care (Washing, Dressing, Etc.)	
☐ I can look after myself normally without causing extra pain	+0
☐ I can look after myself normally but it causes extra pain	+1
☐ It is painful to look after myself and I am slow and careful	+2
☐ I need some help but can manage most of my personal care	+3
☐ I need help every day in most aspects of self-care	+4
☐ I do not get dressed, I wash with difficulty and stay in bed	+5

3. Lifting	
☐ I can lift heavy weights without extra pain	+0
☐ I can lift heavy weights but it gives extra pain	+1
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example, on a table	+2
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned	+3
☐ I can only lift very light weights	+4
☐ I cannot lift or carry anything at all	+5

4. Walking	
☐ Pain does not prevent me walking any distance	+0
☐ Pain prevents me from walking more than 1 mile	+1
☐ Pain prevents me from walking more than ½ mile	+2
☐ Pain prevents me from walking more than 100 yards	+3
☐ I can only walk using a stick or crutches	+4
☐ I am in bed most of the time	+5

5. Sitting	
☐ I can sit in any chair as long as I like	+0
☐ I can only sit in my favorite chair as long as I like	+1
☐ Pain prevents me sitting more than 1 hour	+2
☐ Pain prevents me from sitting more than 30 minutes	+3
☐ Pain prevents me from sitting more than 10 minutes	+4
☐ Pain prevents me from sitting at all	+5

6. Standing	
☐ I can stand as long as I want without extra pain	+0
☐ I can stand as long as I want but it gives me extra pain	+1
☐ Pain prevents me from standing more than 1 hour	+2
☐ Pain prevents me from standing more than 30 minutes	+3
☐ Pain prevents me from standing more than 10 minutes	+4
☐ Pain prevents me from standing at all	+5

7. Sleeping	
☐ My sleep is never disturbed by pain	+0
☐ My sleep is occasionally disturbed by pain	+1
☐ Because of pain, I have less than 6 hours of sleep	+2
☐ Because of pain, I have less than 4 hours of sleep	+3
☐ Because of pain, I have less than 2 hours of sleep	+4
☐ Pain prevents me from sleeping at all	+5

8. Sex life (if applicable)	
☐ My sex life is normal and causes no extra pain	+0
☐ My sex life is normal but causes some extra pain	+1
☐ My sex life is nearly normal but is very painful	+2
☐ My sex life is severely restricted by pain	+3
☐ My sex life is nearly absent because of pain	+4
☐ Pain prevents any sex life at all	+5

9. Social Life	
☐ My social life is normal and gives me no extra pain	+0
☐ My social life is normal but increases the degree of pain	+1
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, for example, sports	+2
☐ Pain has restricted my social life and I do not go out as often	+3
☐ Pain has restricted my social life to my home	+4
☐ I have no social life because of pain	+5

10. Travelling	
☐ I can travel anywhere without pain	+0
☐ I can travel anywhere but it gives me extra pain	+1
☐ Pain is bad but I manage journeys over two hours	+2
☐ Pain restricts me to journeys of less than 1 hour	+3
☐ Pain restricts me to short necessary journeys under 30 minutes	+4
☐ Pain prevents me from traveling except to receive treatment	+5

Scoring instructions:

Raw Score: Summation of Points

Raw Score: ____________ Points

Percentage Score: $\frac{\text{Raw Score}}{\text{\# Completed Questions * 5}}$

Percentage Score: _________ %

Source(s): Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine (Phila Pa 1976) 2000; 25:2940-2952 (41).

Fairbank JC, Couper J, Davies JB. The Oswestry Low Back Pain Questionnaire. Physiotherapy 1980; 66:271-273

Table 18. *Neck Disability Index.*

Neck Disability Index

Patent Name: ________________________________

Date: ____________________________________

1. Pain Intensity	
☐ I have no pain at the moment	+0
☐ The pain is very mild at the moment	+1
☐ The pain is moderate at the moment	+2
☐ The pain is fairly severe at the moment	+3
☐ The pain is very severe at the moment	+4
☐ The pain is the worst imaginable at the moment	+5

2. Personal Care (Washing, Dressing, Etc.)	
☐ I can look after myself normally without causing extra pain	+0
☐ I can look after myself normally but it causes extra pain	+1
☐ It is painful to look after myself and I am slow and careful	+2
☐ I need some help but can manage most of my personal care	+3
☐ I need help every day in most aspects of self-care	+4
☐ I do not get dressed, I wash with difficulty and stay in bed	+5

3. Lifting	
☐ I can lift heavy weights without extra pain	+0
☐ I can lift heavy weights but it gives extra pain	+1
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example, on a table	+2
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned	+3
☐ I can only lift very light weights	+4
☐ I cannot lift or carry anything at all	+5

4. Reading	
☐ I can read as much as I want to with no pain in my neck	+0
☐ I can read as much as I want to with slight pain in my neck	+1
☐ I can read as much as I want with moderate pain in my neck	+2
☐ I can't read as much as I want because of moderate pain in my neck	+3
☐ I can't hardly read at all because of severe pain in my neck	+4
☐ I cannot read at all	+5

5. Headaches	
☐ I have no headaches at all	+0
☐ I have slight headaches, which come infrequently	+1
☐ I have moderate headaches, which come infrequently	+2
☐ I have moderate headaches, which come frequently	+3
☐ I have severe headaches, which come frequently	+4
☐ I have headaches almost all the time	+5

6. Concentration	
☐ I can concentrate fully when I want to with no difficulty	+0
☐ I can concentrate fully when I want to with slight difficulty	+1
☐ I have a fair degree of difficulty in concentrating when I want to	+2
☐ I have a lot of difficulty in concentrating when I want to	+3
☐ I have a great deal of difficulty in concentrating when I want to	+4
☐ I cannot concentrate at all	+5

7. Work	
☐ I can do as much work as I want to	+0
☐ I can only do my usual work, but no more	+1
☐ I can do most of my usual work, but no more	+2
☐ I can't do my usual work	+3
☐ I can hardly do any work at all	+4
☐ I can't do any work at all	+5

8. Driving	
☐ I can drive my car without any neck pain	+0
☐ I can drive my car as long as I want with slight pain in my neck	+1
☐ I can drive my car as long as I want with moderate pain in my neck	+2
☐ I can't drive my car as long as I want because of moderate pain in my neck	+3
☐ I can hardly drive at all because of severe pain in my neck	+4
☐ I cannot drive my car at all	+5

9. Sleeping	
☐ I have trouble sleeping	+0
☐ My sleep is slightly disturbed (less than 1 hr sleepless)	+1
☐ My sleep is mildly disturbed (1-2 hrs sleepless)	+2
☐ My sleep is moderately disturbed (2-3 hrs sleepless)	+3
☐ My sleep is greatly disturbed (3-5 hrs sleepless)	+4
☐ My sleep is completely disturbed (5-7 hrs sleepless)	+5

10. Recreation	
☐ I am able to engage in all recreational activities with no neck pain at all	+0
☐ I am able to engage in all my recreational activities with some pain in my neck	+1
☐ I am able to engage in most but not all of my usual recreational activities because of pain in my neck	+2
☐ I am able to engage in a few of my usual recreational activities because of pain in my neck	+3
☐ I can hardly do any recreational activities because of pain in my neck	+4
☐ I can't do any recreational activities at all	+5

Total Score:

Raw Score: Summation of Points

Raw Score: ___________ Points

Percentage Score: Raw Score / # Completed Questions * 5

Percentage Score: ________ %

Source: Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991; 14:409-415 (43).

Table 19. *Functional status.*

	Baseline or Without Treatment	Average After Treatment or Since Last Visit
Working status	☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Disabled	☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Disabled
Sitting	At a time ________ minutes Total ________ hours	At a time ________ minutes Total ________ hours
Standing	At a time ________ minutes Total ________ hours	At a time ________ minutes Total ________ hours
Walking – feet, blocks or miles	At a time ________ Total ________	At a time ________ Total ________
Climbing stairs (at a time)	____________ flights	____________ flights
Lifting	____________ lbs.	____________ lbs.
Carrying	____________ lbs.	____________ lbs.
Overhead Activities	☐ Normal ☐ Very difficult ☐ Moderately difficult ☐ Unable	☐ Normal ☐ Very difficult ☐ Moderately difficult ☐ Unable
Driving	☐ Normal ☐ Very difficult ☐ Moderately difficult ☐ Unable	☐ Normal ☐ Very difficult ☐ Moderately difficult ☐ Unable

Table 20. *KATZ index of independence in activities of daily living.*

Activities Points (1 or 0)	Baseline or without treatment	Average after treatment or since last visit
BATHING Independence: Bathes self completely or needs help in bathing only a single part of the body. Dependence: Need help with bathing more than one part of the body	☐ 1 - Independence ☐ 0 - Dependence	☐ 1 - Independence ☐ 0 - Dependence
DRESSING Independence: Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. Dependence: Needs help with dressing	☐ 1 - Independence ☐ 0 - Dependence	☐ 1 - Independence ☐ 0 - Dependence
TOILETING Independence: Goes to toilet independently Dependence: Needs help	☐ 1 - Independence ☐ 0 - Dependence	☐ 1 - Independence ☐ 0 - Dependence
TRANSFERRING Independence: Moves in and out of bed or chair unassisted Dependence: Needs help	☐ 1 - Independence ☐ 0 - Dependence	☐ 1 - Independence ☐ 0 - Dependence
CONTINENCE Independence: Exercises complete self-control over urination and defecation. Dependence: Is partially or totally incontinent of bowel or bladder	☐ 1 - Independence ☐ 0 - Dependence	☐ 1 - Independence ☐ 0 - Dependence
FEEDING Independence: Gets food from plate into mouth without help Dependence: Needs partial or total help feeding	☐ 1 - Independence ☐ 0 - Dependence	☐ 1 - Independence ☐ 0 - Dependence
TOTAL POINTS - SCORING: 6 = High (patient independent) 0 = Low (patient very dependent)		

on the available literature, patients characterized as high-risk are at increased likelihood of future abusive drug-related behavior (51). The ORT has been validated in both male and female patients; however, not in non-pain populations. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse (46,49).

Table 22 shows SOAPP Version 1.0-14Q. To score the

SOAPP Version 1.0-14Q, the ratings of all the questions are simply added. A score of 7 or higher is considered positive. The specificity increases as the scores increase to 9 or above, increasing from sensitivity of 0.91 and specificity of 0.69 with positive predictive value of 0.71 at score of 7 to 0.77 sensitivity and specificity of 0.8 with a positive predictive value of 0.77 with a score of 9 or above (52).

At the Pain Management Centers of America (PMCOA), we also have developed a comprehensive testing, which includes multiple factors not described in SOAPP and relatively easy to assess, giving us a more comprehensive score as shown in Table 23. While this test has not been validated, our experience in thousands of patients shows significant correlation and reliability. In addition, we utilize this test in addition to SOAPP-R. Consequently, the final scoring is based on SOAPP-R score plus the PMCOA risk assessment score, including multiple categories based on the risk stratification and composite score as follows:

Table 21. *Opioid risk tool.*

Mark each box that applies	**Female**	**Male**
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16 - 45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		
Risk classification: ≥ 8 high risk 4-7 moderate risk ≤ 3 low risk		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction. Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Med* 2005; 6:432-442 (46).

Table 22. *Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R).*

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R)						
Name:		Date:				
Please answer the questions as honestly as possible below using the following scale: 0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often						
		Never	**Seldom**	**Sometimes**	**Often**	**Very Often**
		0	**1**	**2**	**3**	**4**
1	How often do you have mood swings?	❍	❍	❍	❍	❍
2	How often do you smoke a cigarette within an hour after you wake up?	❍	❍	❍	❍	❍
3	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	❍	❍	❍	❍	❍
4	How often have any of your close friends had a problem with alcohol or drugs?	❍	❍	❍	❍	❍
5	How often have others suggested that you have a drug or alcohol problem?	❍	❍	❍	❍	❍
6	How often have you attended an AA or NA meeting?	❍	❍	❍	❍	❍
7	How often have you taken medication other than the way that it was prescribed?	❍	❍	❍	❍	❍
8	How often have you been treated for an alcohol or drug problem?	❍	❍	❍	❍	❍
9	How often have your medications been lost or stolen?	❍	❍	❍	❍	❍
10	How often have other expressed concern over your use of medication?	❍	❍	❍	❍	❍
11	How often have you felt a craving for medication?	❍	❍	❍	❍	❍
12	How often have you been asked to give a urine screen for substance abuse?	❍	❍	❍	❍	❍
13	How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	❍	❍	❍	❍	❍
14	How often, in your lifetime, have you had legal problems or been arrested?	❍	❍	❍	❍	❍
Please include any additional information you wish about the above answers. Thank you.						

Table 23. *Patient risk assessment: Risk stratification explanation for scoring.*

1. Smoking (1-4) Current within last 6 months 1 Rare - once or twice a week or e-cigarette 2 ½ PPD or 10 cigarettes within the past year 3 1 PPD or 20 cigarettes within the past year 4 > 1 PPD or more than 20 cigarettes within the past year	11. Methadone (2-4) 2 Methadone 30 mg/day 4 Methadone > 30 mg/day
2. ADD/ADHD, OCD, bipolar, schizophrenia (1-6) 1 ADD/ADHD 1 OCD 2 Bipolar 2 Schizophrenia Add combinations	12. Doctor Shopping (2-8) 1 Rare 2 Occasional 3 Frequent 4 Very frequent
3. Depression (1-4) 1 Mild - no treatment 2 Moderate - treat 3 Severe - treat 4 Very severe - treat	13. Drug Overdose (5) 5 Multiply for multiple amounts
4. Anxiety (1-4) 1 Mild - no treatment 2 Moderate - treat with antidepressants/or BuSpar/or no treatment 3 Severe - treat with Benzodiazepines/psychotherapy or no treatment 4 Very severe - Benzodiazepines + psychotherapy or no treatment	14. Soma (2-4) 1 < 750 mg daily 2 > 750 mg daily
5. Somatization Disorder (3)	15. Dealing in Drugs (5) 5 Multiply for multiple dealings
6. PTSD (1-4) 1 Mild - no effect 2 Moderate 3 Severe 4 Very severe	16. Suicide Attempts (5) 5 Multiply for multiple attempts
7. Sex Abuse (3-6) ↑ for multiple abuses	17. Sleep Apnea Syndrome (2)
8. More Medication (1-4) 1 Mild - request 2 Moderate - request somewhat infrequently 3 Significant - demanding, manipulative, repetitive 4 Extensive - involving abuse patterns	18. Fibromyalgia (1)
9. High Dose Opioids (2-4) 1 <= 90 MMEQ 2 91-120 MMEQ 3 121-240 MMEQ 4 > 240 MMEQ	19. Prescription Drugs from Street or Others (5)
10. Benzodiazepines (1-4) 1 Mild - prn, low dose/infrequent 2 Moderate - ≤ 10 mg diazepam daily or equivalents 3 High - 11- 29 mg diazepam daily or equivalents 4 Very high - > 30 mg diazepam daily or equivalents	20. Illicit Drugs from Streets (5)

SOAPP SCORE:
_____ (Table 22) + RISK STRATIFICATION SCORE:
_____ (Table 23)
= _____ FINAL SCORE
OVERALL RISK:
Very High Risk (≥ 24): _____
High Risk (14-23): _____
Moderate Risk (7-13): _____
Low Risk (< 7): _____

Other Documentation Requirements

There are multiple other documentation requirements which are related to opioid management, including indications, complications, and comorbidity assessment (53-59).

Other nonopioid documentation requirements are also present, which include indications and medical necessity for interventional techniques, complications of interventional techniques, steroids, indications for therapeutic facet joint procedures, and reasons for not using steroids in the treatment modalities when it is required.

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