

POLICY-DOCUMENTATION GUIDELINES

Introduction

What is documentation & why is it important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time;
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- Accurate and timely bill review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful for research and education.

This would include identifying demographic information for the claimant in order to image medical record documentation. An appropriately documented medical record can reduce many of the "issues" associated with bill processing and may serve as a legal document to verify the care provided, if necessary.

What Does BWC Want & Why?

Because we have an obligation to employers, they may request documentation that services are consistent with the coverage provided. For this reason BWC requires information to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services provided have been accurately reported;
- That services are related to the allowed claim condition.

General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings.

1. The medical record shall be complete and legible.
2. The documentation of each patient encounter shall include:
 - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
 - assessment, clinical impression, or diagnosis;
 - plan for care; and
 - date and legible identity of the patient and the author.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses along with allowed conditions should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT, Level II and Level III HCPCS and ICD codes reported on the CMS-1500 or C-19 must be supported by the documentation in the medical record.

Please note-For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed above may be modified to account for these variable circumstances in providing E/M services.

APPENDIX A

Evaluation & Management Guidelines

These guidelines have been developed jointly by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). Either 1995 or 1997 Evaluation & Management guidelines can be used for code selection, whichever is most favorable to the provider.

Documentation of E/M Services

For purposes of a new patient service, it is defined as a patient who has not sought treatment by a provider or a provider in the group of the same specialty within the last three years. The initial service must be provided in a face-to-face visit. For a patient considered an “established patient”, an injury or worsening of the condition that causes a repeat office visit requiring a more thorough evaluation including, but not limited to, a more complete history, examination, occupational history, and revision of work restrictions, a higher level evaluation code may be appropriate. This may include an injured worker with a new injury, though the injured worker based on accepted terminology is considered an “established patient”.

This policy provides definitions and documentation guidelines for the three *key* components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components--**history, examination, and medical decision making**--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history
- examination
- medical decision making
- counseling
- coordination of care
- nature of presenting problem
- time

The first three of these components (history, examination, and medical decision making) are the *key* components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

Documentation of History

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s). The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.) History of Present Illness (HPI), Review of Systems (ROS), Past, Family, and/or Social History (PFSH).

Type of History

HPI	ROS	PFSH	
Brief	N/A	N/A	Problem Focused
Brief	Problem Pertinent	N/A	Expanded Problem Focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

***** The CC, ROS, and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.**

*****A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by: describing any new ROS and/or PFSH information or noting there has been no change in the information; and noting the date and location of the earlier ROS and/or PFSH.**

*****The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.**

*****If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.**

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

*****The medical record should clearly reflect the chief complaint.**

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location;
- quality;
- severity;
- duration;
- timing;
- context;
- modifying factors; and
- associated signs and symptoms.

Brief and *extended* HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A *brief* HPI consists of one to three elements of the HPI.

***The medical record should describe one to three elements of the present illness (HPI).

An *extended* HPI consists of four or more elements of the HPI.

***The medical record should describe four or more elements of the present illness (HPI)

1997 GUIDELINES- Extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

*** The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For purposes of ROS, the following systems are recognized:

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

A *problem pertinent* ROS inquires about the system directly related to the problem(s) identified in the HPI.

***The patient's positive responses and pertinent negatives for the system related to the problem should be documented.

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

***The patient's positive responses and pertinent negatives for two to nine systems should be documented.

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

***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 are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities). **This criterion could be met by a thorough occupational history, which is often necessary for documentation of causality and return to work restrictions.**
- For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

A pertinent PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

*****At least one specific item from any of the three history areas must be documented for a pertinent PFSH.**

A *complete* PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

*****At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.**

*****At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.**

Documentation of Examination (1995 and 1997)

The levels of E/M services are based on four types of examination that are defined as follows:

Problem Focused -- a limited examination of the affected body area or organ system.

Expanded Problem Focused -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive -- a general multi-system examination or complete examination of a single organ system.

For purposes of 1995 examination, the following *body areas* are recognized:

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

For purposes of 1995 examination, the following *organ systems* are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of 1997 examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

*****Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.**

***** Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.**

*****A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).**

*****The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.**

Parenthetical examples "(e.g.,...)" have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as "Measurement of *any three of the following seven*...") included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as "Examination of *liver and spleen*") require documentation of at least one component. It is possible for a given examination to be

expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

*****Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.**

*****Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.**

*****A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).**

Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

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. Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

*****For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation. For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving, or resolved; or, b) inadequately controlled, worsening, or failing to change as expected. For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (R/O) diagnoses.**

***** Return to work restrictions, which can be quite complex, are essential in the management of injured workers and are valued as a part of the management option. Determining work restrictions and physical capacity estimates may increase the complexity of management options.**

*****The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.**

*****If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.**

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed. Discussion of contradictory or unexpected test results with the physician who performed or interpreted

the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

*****If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.**

*****The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.**

*****A decision to obtain old records or decision to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.**

***** Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker, or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "old records reviewed" or "additional history obtained from family" without elaboration is insufficient.**

*****The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.**

*****The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.**

***** BWC administrative forms that are completed during a visit will be counted as a data element and will be worth 2 points, regardless of the number of forms.**

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

*****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.**

*****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.**

*****The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.**

TABLE OF RISK

The table on the following page may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is *minimal*, *low*, *moderate*, or *high*. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. 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 one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

TABLE OF RISK

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTION SELECTED
Minimal	<ul style="list-style-type: none"> -One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> -Laboratory tests requiring venipuncture -Chest x-rays -EKG/EEG -Urinalysis -Ultrasound, (e.g. (echocardiography) -KOH prep 	<ul style="list-style-type: none"> -Rest -Gargles -Elastic bandages -Superficial dressings
Low	<ul style="list-style-type: none"> -Two or more self-limited or minor problems -One stable chronic illness, (e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH) -Acute uncomplicated illness or injury, (e.g., cystitis, allergic rhinitis, simple sprain) 	<ul style="list-style-type: none"> -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 	<ul style="list-style-type: none"> -Over-the-counter drugs -Minor surgery with no identified risk factors -Physical and Occupational therapy -IV fluids without additives
Moderate	<ul style="list-style-type: none"> -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) -Acute illness with systemic symptoms, (e.g., pyelonephritis, pneumonitis, colitis) -Acute complicated injury, (e.g. head injury with brief loss of consciousness) 	<ul style="list-style-type: none"> -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 catheterization -Obtain fluid from body cavity, (e.g., lumbar procedure, thoracentesis, culdocentesis) 	<ul style="list-style-type: none"> -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 fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> -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 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) 	<ul style="list-style-type: none"> -Cardiovascular imaging studies with contrast with identified risk factors -Cardiac electrophysiological tests -Diagnostic endoscopies with identified risk factors -Discography 	<ul style="list-style-type: none"> -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

Documentation of an Encounter Dominated by Counseling or Coordination of Care

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

***** If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.**

*****If a BWC certified provider documents that additional time was required to complete forms or counsel the patient regarding return to work restrictions, this time may be considered in the selection of the Evaluation and Management code.**

Consultation

BWC will reimburse a consultation when all of the criteria for the use of a consultation code are met:

- A consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. A written or verbal request for consult must be made by a physician or other appropriate source and documented in the patient's medical record;
- The consultant must provide an opinion and/or services, which must be documented in the patient's medical record; and
- The consultant's opinion and/or services must be communicated back to the requesting physician or other appropriate source via *written* report, a copy of which should be kept in the patient's medical record.
- In order to report any of the office or other outpatient consultation codes, criteria must be met with regard to all three components of history, physical examination, and medical decision-making. However, if greater than fifty percent of the consultation is spent in counseling/coordinating care, then the consultant can select a level of service using time as the key factor.

Telephone Calls (99371-99373 CPT ®)

Provider telephone calls may be reimbursed by BWC. These calls must be medically necessary or contribute to the overall care of the injured worker. Telephone calls must have supporting documentation in the medical record with a brief description of the conversation noted. These codes are not to be used in addition to consultation services (99241-99255) or team conferences (99361 and 99362). The telephone call CPT codes (99371-99373) are not to be submitted for conversations with an MCO or BWC. These calls are not to serve as a replacement for face-to-face interaction with the injured worker.

99371-This code is to be used for a simple or brief telephone call. It serves a multitude of purposes and can involve a variety of parties. It can be used when a provider calls the patient, for consultative reasons, medical management or for coordinating medical management with other health care professionals. It may also be used for discussion with the employer regarding an injured worker's status. Topics of discussion could include, but are not limited to, test and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, to adjust therapy, to report on progress of treatment, update the patient's return to work status and job restrictions. Most provider telephone calls will fit into this category.

99372-This code is to be used for an intermediate telephone call when initiating therapy that can be handled by telephone, to discuss and evaluate new information and details or to initiate a new plan of care. BWC would expect a conversation of this type to require at least 20 minutes of provider time.

99373-This code is to be used for complex or lengthy telephone calls. It would involve a lengthy, emergent counseling session with an anxious or distraught patient or detailed or prolonged discussion with family members regarding a seriously ill patient. BWC would expect a conversation of this type to be a rare occurrence and require at least 30 minutes of provider time.

APPENDIX B

Osteopathic Manipulation Therapy Coding Guidelines

The following coding guidelines should be used when coding/billing Osteopathic Manipulation Therapy:

- Osteopathic manipulative treatment includes a pre and post manipulation assessment. Pre-service work includes: reviewing previously gathered clinical data, an initial or interim history, reviewing the problem list, pertinent correspondence or reports, other important findings, prior care, review of imaging and other test results, test interpretation, and care planning.
- Osteopathic manipulation to regions of the body that does not correlate with specific regions where somatic (bodily) dysfunction is documented by the physical examination will not be covered.
- OMT may be done in any appropriate setting such as hospital, office or home.
- The outcome or response to treatment must be included in the record.
- The plan for ongoing care is noted.
- In addition, treatment will not be routinely reimbursed in more than two claims. If two body regions are allowed and treated, one in each of two claims, CPT[®] code 98925 may be billed in each claim with BWC modifier **PC** for the primary claim and **SC** for the second claim.
- If a total of **three or four body regions are allowed and treated** in two claims, two in one claim and one or two in a second claim, each claim may be coded with **98926**. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.
- If a total of **five or six body regions are allowed and treated** in two claims, each service may be coded with **98927**. For the primary or most significant service, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.

The OMT procedure codes are related almost exclusively to the somatic (bodily) dysfunction codes. An E/M service may be billed on the same day as OMT if the service is significant and separately identifiable from the OMT, and CPT modifier 25 is used.

- Examples could include the first visit, at which a patient is examined, or when a significant change in the patient's condition warrants an additional evaluation.
- An E/M service should also be reported if work is done that is not included in the OMT (e.g., change of medications, review of additional or new data, or the ordering of laboratory imaging studies, x-rays, or additional studies).

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. CPT[®] codes

98925	Osteopathic manipulation (1-2 body regions)
98926	Osteopathic manipulation (3-4 body regions)
98927	Osteopathic manipulation (5-6 body regions)
98928	Osteopathic manipulation (7-8 body regions)
98929	Osteopathic manipulation (9-10 body regions)

APPENDIX C

Chiropractic Services

Chiropractic manipulative treatment is a form of manual treatment to influence joint and neurophysical function. This treatment may be accomplished using a variety of techniques. For purposes of CMT, the five spinal regions referred to are: cervical region, (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacro-iliac joint) region. The five extraspinal regions referred to are: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities: rib cage: (excluding costotransverse and costovertebral joints) and abdomen. The following documentation guidelines should be used when coding/billing Chiropractic Manipulative Treatment:

- Chiropractic manipulative treatment includes a pre manipulation assessment. Pre-service work includes: reviewing previously gathered clinical data, an initial or interim history, reviewing the problem list, pertinent correspondence or reports, other important findings, prior care, review of imaging and other test results, test interpretation, and care planning.
- The outcome or response to treatment must be included
- The plan for ongoing care is noted
- In addition, treatment will not be routinely reimbursed in more than two claims. If two body regions are allowed and treated, one in each of two claims, CPT® code **98940** may be billed in each claim with BWC modifier **PC** added to the primary procedure and **SC** added to the code in the second claim.
- If a total of **three or four spinal regions are allowed and treated** in two claims, two in one claim and one or two in a second claim, each claim may be coded with **98941**. For the primary or most significant service, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.
- If a total of **five spinal regions are allowed and treated** in two claims, each service may be coded with **98942**. For the primary or most significant service, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.

An E/M service may be billed on the same day as CMT if, and only if, the patient's condition requires a significant and separately identifiable service above and beyond the usual pre-service work associated with the procedure. Modifier 25 is appended to the CPT® code.

- Examples could include the first visit, at which time a patient is examined, or when a significant change in the patient's condition warrants an additional evaluation.
- An E/M service should also be reported if work is done that is not included in the CMT (e.g., review of additional or new data, or the ordering of laboratory imaging studies, x-rays, or additional studies).

CPT codes

98940	Chiropractic manipulation; spinal, 1-2 regions
98941	Chiropractic manipulation; spinal, 3-4 regions
98942	Chiropractic manipulation spinal, 5 regions
98943	Chiropractic manipulation extraspinal, 1 or more regions

APPENDIX D

Physical and Rehabilitative Therapies

Physical, Occupational and Massage Therapy Documentation

- Documentation must support the CPT® code submitted.
- The medical record must include the amount of time submitted for time-based physical and massage therapy codes.
- A plan of care should be included.
- The medical record must include the flow sheet of modalities and exercises with treatment and a short narrative of function and status with a summary of response.

Time-Based Guidelines

BWC guidelines regarding time-based codes are as follows:

- **Record the time in the medical record.** The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. The time spent delivering each service, described by a timed code should be recorded. (The length of the treatment to the minute could be recorded instead.)
- **Be aware of time calculations for multiple procedures.** If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of CPT code 97112 and 23 minutes of CPT code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is 2 units of CPT code 97112 and one unit of CPT code 97110, assigning more units to the service that took the most time. Refer to the following chart:

Units Reported on the Claim	Number Minutes
<u>1 unit</u>	> 8 minutes to < 23 minutes
<u>2 units</u>	<u>≥ 23 minutes to < 38 minutes</u>
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

- These instructions also apply to multiple units of a single CPT® code.
- Do not submit a claim for services performed for less than 8 minutes (**note: when multiple time-based procedures are performed, if the duration of any one procedure is less than 8 minutes and the total treatment time exceeds 8 minutes, this time should still be figured into the total treatment time for the patient on that date.**)
- **Time starts when the therapist is working directly with the patient.** Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as “intra-service care” begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.
- **The time counted is the time the patient is treated.** For example, if gait training requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of CPT code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

APPENDIX E

Psychotherapy

Individual Psychotherapy Documentation and Coding Guidelines

Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change. Face-to-face time spent with the patient during psychotherapy shall be noted in the medical record.

- Providers must submit the procedure code that most closely matches the face-to-face time spent with the patient.
- When submitting a bill for a time-based psychotherapy code, the quantity billed field must be one for each date of service.
- The ICD code that reflects the primary psychiatric disorder allowed (e.g., depression, psychosis) necessitating psychotherapy must be submitted on the bill.

Psychotherapy Notes

Provider Types Affected

Psychotherapists and providers billing BWC for psychotherapy services.

Provider Action Needed

This provides information about instructions to MCOs not to deny claims for psychotherapy on the basis that providers failed to produce psychotherapy notes in response to a broad request for documentation. Providers are exempt from submitting psychotherapy notes without patient authorization when the notes in question fit the Final Privacy Rule, 45 CFR, Section 164.501. However, patient authorization is not required for the release of information excluded from the definition of psychotherapy notes, and the provider shall release the non-psychotherapy note material to demonstrate medical necessity.

The definition of psychotherapy notes expressly excludes the following information:

- Medication prescription and monitoring,
- Counseling session start and stop times,
- Modalities and frequencies of treatment furnished,
- Results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.

The preceding class of information does not qualify as psychotherapy note materials, and physically integrating this information into protected psychotherapy notes does not automatically transform it into protected information.

It is important to note that if a provider has combined information excluded from the definition of psychotherapy notes with a psychotherapy note (e.g., symptoms), it is the responsibility of the provider to extract the information needed to support that a BWC claim is reasonable and necessary.

Also, providers are exempt from submitting psychotherapy notes without a separate patient authorization when the notes in question fit the Privacy Rule definition in, 45 CFR, Part 164.501.

**BWC DOCUMENTATION REQUIREMENTS
NEW PATIENT/CONSULTS - OUTPATIENT SERVICES**

Physician _____ Date _____ Patient _____ Claim # _____

DOB _____ DOS _____ Chief Complaint _____ Auditor _____

NEW PATIENT (3 out of 3 components)		***Time listed in CPT is an average only and not a requirement	99201/99241/ 99251 Focused	99202/99241 99251 Ex Prob Foc	99203/99243 99253 Detailed	99204/99244 99254 Comprehensive	99205/99245 99255 Comprehensive	
HISTORY (3 out of 3)	HPI	Loc Dur Timing S&S Qual Sev Cont Mod Factors	Brief (1-3)	Brief (1-3)	4active/ <i>3chronic</i>	4 active/ <i>3chronic</i>	4 active/ <i>3chronic</i>	
	ROS	Cons Eyes ENMT CV Resp GI GU MS Integ Neuro Endo Psych Hem/Lymph All/Immuno All others NEG		PP (1)	Ext (≥2)	Complete (≥10)	Complete (≥10)	
	PFSH	Past Med Family Social(includes occupational)			1 of 3	3 of 3	3 of 3	
EXAM (Either '95 or '97 guidelines are acceptable, whichever is most favorable to the provider)		Org Sys:	1995 – 1 body area or system related to prob 1997 -1 – 5 bullets	1995 – 2-7 body areas or systems RTP 1997 - ≥6 bullets	1995 – 2-7 body areas or systems RTP, at least one in detail 1997 - ≥2 bullets from each of 6 systems or ≥12 bullets in at least 2 systems	1995 – 8 or more systems or complete exam of single system 1997 - ≥2 bullets from each of 9 systems	1995 – 8 or more systems or complete exam of single system 1997 - ≥2 bullets from each of 9 systems	
		Const						Hem/LymImmuno
		Eyes						
		ENMT						Body Ar:
		CV						Head
		Resp						Neck
		GI						Chest
		GU						Abd
		MS						Gen, etc
Skin	Back							
Neuro	Each ext							
Psych								
MED DECISION MAKING		(2 out of 3)	Level 1	Level 2	Level 3	Level 4	Level 5	
	MGT OPT	(includes RTW restrict.)	Minimal (1)	Minimal (1)	Limited (2)	Multiple (3)	Extensive (4) Extensive (4) High (4)	
	AMT DATA	(BWC Forms-max 2 pts)	Minimal (1)	Minimal (1)	Limited (2)	Multiple (3)		
	RISK	(See Table)	Minimal (1)	Minimal (1)	Low (2)	Moderate (3)		

MISSING DOCUMENTATION/COMMENTS

CPT Documented	CPT Billed	ICD Documented	ICD Billed

**BWC DOCUMENTATION REQUIREMENTS
ESTABLISHED PATIENT - OUTPATIENT SERVICES**

Date _____ Physician _____ Patient _____ Claim # _____

DOS _____ Auditor _____ Chief Complaint _____

ESTABLISHED PATIENT (2 out of 3 components)		Time indicated is an average only and not a requirement		99211 (5 min)	99212 Prob. Focused (10 min)	99213 Exp. Prob. Focus (15 min)	99214 Detailed (25 min)	99215 Comprehensive (40 min)
HISTORY (3 of 3) Notes: HPI notes in <i>italics</i> not applicable to 1995 guidelines	HPI	Loc Dur Timing Quality S&S Severity Cont Mod Factors			Brief (1-3)	Brief (1-3)	4 active/3 <i>chronic</i>	4 active/3 <i>chronic</i>
	ROS	Cons Eyes ENMT CV Resp GI GU MS Integ Neuro Endo Psych Hem/Lymph All/Immuno All others NEG				PP (1)	Exp (2-9)	Complete (≥10)
	PFSH	Past Medical Family Social (incl occupational)					1 of 3	2 of 3
EXAM (Either '95 or '97 guidelines are acceptable, whichever is most favorable to the provider)	Org Sys:	Hem/ Lymph/ Immun	DOES NOT REQUIRE PHYSICIAN ATTENDANCE- MUST NOT BE NEW PROBLEM or a NEW PATIENT		1995 – 1 body areas or systems RTP	1995 – 2-4 body areas or systems RTP	1995 – 5-7 body areas or systems RTP	1995 – 8 or more systems or complete exam of single system
	Const							
	Eyes							
	ENMT	Body Ar:						
	CV	Head						
	Resp	Neck						
	GI	Chest						
	GU	Abd						
	MS	Gen, etc						
Skin	Back							
Neuro	Each ext							
Psyc								
MED DECISION MAKING		(2 out of 3)		Level 1	Level 2	Level 3	Level 4	Level 5
	MGT OPT	(includes RTW restrict.)			Minimal (1)	Limited (2)	Multiple (3)	Extensive (4) Extensive (4) High (4)
	AMT DATA	(BWC Forms-max 2 pts)			Minimal (1)	Limited (2)	Multiple (3)	
	RISK	(See Table)			SF(1)	Low (2)	Moderate (3)	

MISSING DOCUMENTATION/OTHER:

CPT Level of Service Documented	CPT Billed	ICD Documented	ICD Billed

MEDICAL DECISION MAKING

DIAGNOSIS/MANAGEMENT OPTIONS: Identify each problem evaluated in the record and classify; enter total number of **each** type of problem

Problem Categories	Number	Points	Score
Self-limited or minor (stable, improving, or worsening)	(Maximum = 2)	1	
Established Diagnosis/Problem, stable, improved		1	
Established Diagnosis/Problem, worsening		2	
New problem to provider, NO additional work-up planned	(Maximum = 1)	3	
New problem to provider, additional work-up planned/consultation		4	
		TOTAL	

TYPE OF DATA

POINTS	TYPE OF DATA
1	Review and/or order clinical lab tests
1	Review and/or order tests in 7XXXX series of CPT codes
1	Review and/or order tests in 9XXXX series of CPT codes
1	Discuss test results with the performing/interpreting provider
2	Independent review of image, tracing or specimen
1	Decision to obtain old records and/or decision to obtain history from others
2	Review AND summarize old records and/or history obtained from others
2 (MAX)	Completion of BWC Administrative forms
	TOTAL