

Evidence-Based Medicine



Description of Documentation in the Management of Chronic Spinal Pain

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Documentation assists health care professionals in providing appropriate services to patients by documenting indications and medical necessity, and reflects the competency and character of the physician. Documentation is considered a cornerstone of the quality of patient care. This is nowhere more true than in interventional pain management. Thus, documentation in physicians' offices, hospital settings, ambulatory surgery centers, rehabilitation centers, and other settings must be accurate, complete, and reflect all of the services provided during each encounter.

The Centers for Medicare and Medicaid Services (CMS) defines medical necessity in these terms: "no payment may be made under Part A or Part B for any expense incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a participant." The American Medical Association (AMA) defines medical necessity as, "health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider."

Documentation requirements include an appropriate medical record utilizing recognized and acceptable standards of documentation and an established process. However, the evolution of electronic medical records (EMRs) or electronic health records (EHRs) nullifies many of the issues faced in handwritten documentation.

Multiple types of documentation include evaluation and management services and documentations in ambulatory surgery centers, hospital outpatient departments, and in office settings, specifically while performing interventional procedures. Evaluation and management services incorporate 5 levels of service for consultations and visits, with multiple key elements of service including history, physical examination, and medical decision making.

Documentation of interventional procedures in general requires a history and physical, indication and medical necessity, intra-operative procedural description, post-operative monitoring and ambulation, discharge, and disposition. With minor variations, these requirements are similar for an in-office setting, hospital outpatient department, and ambulatory surgery centers.

Key words: Documentation, billing, coding, compliance, fraud and abuse, interventional techniques, evaluation and management services, office visit, consultation, new patient, established patient

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Documentation of medical services is necessary to provide information to assist health care professionals in providing services to patients which are medically necessary and indicated. Documentation also reflects the competency and character of the physician and assists in billing and coding. Documentation includes evaluation and management and procedural services. Even though health care is not that different from other industries and services, documentation has taken priority and become an inevitable and even desirable part of medical practice (1-12). The role played by documentation has always been a supportive one, but critical. As the practice of medicine has become more sophisticated and complex, the need to record specific clinical data has grown in importance. What began as a simple written mechanism to remind the treating physician has evolved into a refined system to serve others assisting in patient care. Until the early 1970s, no clear standards existed for medical record documentation. Prior to the era of fraud and abuse in medicine, medical documentation was not only maintained by , but was considered to be the property of, the physician or facility and was used almost exclusively by physicians and staff.

Developments in the mid 1970s irrevocably affected the role of documentation in medicine. This was fueled by a dramatic nationwide increase in medical liability claims and awards, changes in the fledgling Medicare program during the 70s, and the emergence of the electronic review process in 1980s. Medicare Prospective Payment Systems, documentation for evaluation and management services in the early 1990s, the Health Insurance Portability and Accountability Act (HIPAA), explosive growth of medical expenditures, perceived fraud, abuse, and overuse, the Medicare Modernization Act (MMA) of 2003, and pay for performance strategies propelled the growth and importance of documentation (13-18).

1.0 AN INTRODUCTION TO DOCUMENTATION

Documentation is not limited only to physician and provider organizations. A U.S. Government Accountability Office (GAO) study submitted to Ways and Means Health Subcommittee on September 25, 2001, showed that Medicare carriers were wrong approximately 85% of the time and provided incorrect or incomplete answers (13). A repeat study by the GAO in 2004 showed that 96% of the time, answers to billing questions by Medicare carriers were incomplete, only partially correct, or totally incorrect. To-

tally incorrect responses were provided 54% of the time (14). The GAO in a 2006 study (15) also showed that insurers offering prescription drug coverage through Medicare routinely failed to provide accurate and complete responses to questions posed over the telephone by federal investigators. The study showed that accurate and complete answers were provided only 34% of the time, and no answer was provided for 15% of the questions posed. Inaccurate answers were provided in 22% of cases, with incomplete answers in 29% of the cases, and in half of the cases, the response was improper. Error rates also have been determined for Medicare carriers, ranging from 6.1% to 25.7% with an average of 14.4% (12). No such data is available for third party payors.

The Office of Inspector General (OIG) reported overpayments of \$23.3 billion in 1996 with an error rate of 14.2%, declining to \$10.8 billion or 3.9% in 2007 in the Medicare program as shown in Table 1 (12). It has been demonstrated that increased efforts to prevent fraud and abuse have reduced the Medicare fee-for-service (FFS) error rates significantly (Fig. 1). A June 2008 GAO report (16) also showed that thousands of Medicare providers abuse the federal tax system. The analysis of data provided by CMS and the IRS indicated that over 27,000 health care providers (i.e., about 6% of all said providers) paid under Medicare during calendar year 2006 had payroll and other agreed-to federal tax debts totalling over \$2 billion. However, the \$2 billion figure is understated because some of these Medicare providers owe taxes under separate tax identification numbers (TIN) from the TINs that received the Medicare payments or they did not file their tax returns.

1.1 Fraud and Abuse

The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (17) promulgated a joint health care fraud and abuse control (HCFAC) program, which went into effect on January 1, 1997. HIPAA requires DHHS and the Department of Justice (DOJ) to report annually on HCFAC program results and accomplishments. Consequently, OIG is not alone in the fight to combat fraud and preserve the integrity of the federal health care programs. They work closely with the DOJ and state law enforcement agencies, as well as, CMS and the Food and Drug Administration (FDA).

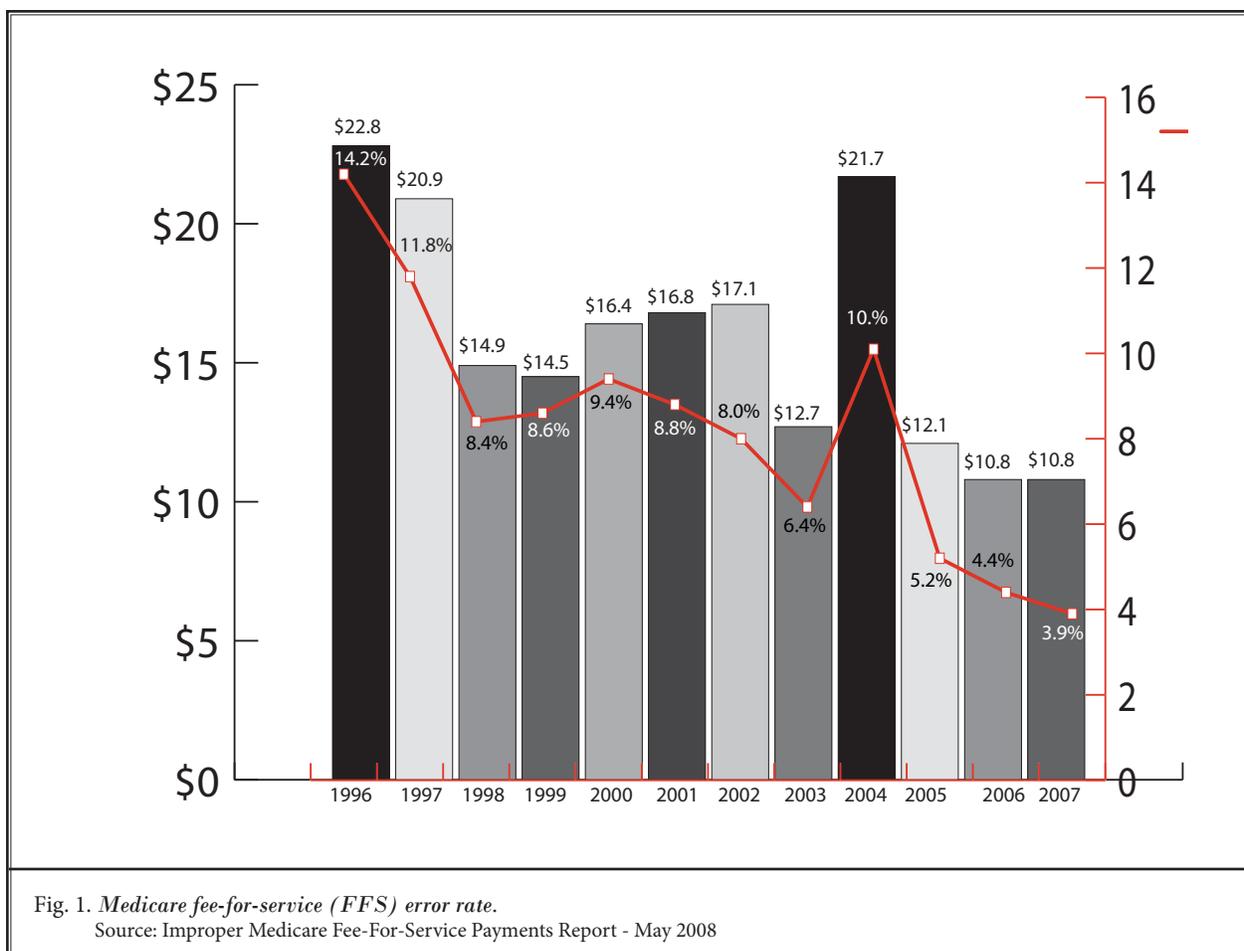
In its eleventh year of operation, the HCFAC program continues to be successful, confirming the soundness of a collaborative approach to identify and prosecute health care fraud, to prevent future fraud and

Table 1. Proportion of improper payments by type of error.

Type of Error	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
	Net	Gross	Gross	Gross	Gross							
No/Insufficient documentation errors	46%	44%	17%	40%	37%	43%	29%	81%	71%	36%	27%	25%
Medically unnecessary services	37%	37%	55%	33%	42%	43%	57%	11%	16%	31%	32%	33%
Coding errors	9%	15%	18%	16%	15%	17%	14%	7%	12%	29%	36%	37%
Others	8%	4%	10%	11%	6%	(3%)*	0%	1%	1%	4%	5%	5%
Improper Payments (Billions)	\$ 23.8	\$20.9	\$14.9	\$14.5	\$16.4	\$16.8	\$17.1	\$12.7	\$21.7	\$12.1	\$10.8	\$10.8
Total payments (Billions)	\$168.1	\$177.9	\$177.0	\$168.9	\$174.6	\$191.3	\$212.8	\$199.1	\$213.5	\$234.1	\$246.8	\$276.2
% over total dollars paid	14.2%	11.8%	8.4%	8.6%	9.4%	8.8%	8.0%	6.4%	10.1%	5.2%	4.4%	3.9%

* For 2001 the (3.1%) applied primarily to other errors. In these cases, medical reviewers determined that the amounts billed should have been higher or that amounts previously denied.

Source: Improper Medicare Fee-For-Service Payments Report, May 2008



abuse, and protect Medicare and Medicaid beneficiaries (19). Since its inception, HCFAC program activities have returned over \$11.2 billion to the Medicare Trust Fund. The strategy is broader than investigating and prosecuting detected instances of fraud, and has also been informed by OIG audits, evaluations, and inspections, which have identified payments for unallowable services and improper services not rendered, and other types of improper claims.

OIG found that from 2000 through 2006, Medicare spending for physician imaging services doubled from about \$7 billion to about \$14 billion. This is an average annual increase of 13 percent, compared to an 8 percent increase in spending for all Medicare physician-billed services over the same time period. Services provided by independent diagnostic testing facilities (IDTFs) accounted for nearly 30% of this growth (20).

The United States spent \$2.2 trillion on health care in 2007 (21,22). The National Health Care Anti-Fraud Association estimates conservatively that of that amount, at least 3% — or more than \$60 billion each year — is lost to fraud. In addition to issues related to fraud, the OIG reviews and identifies unallowable services, improper coding, and other types of improper payments for various inpatient and outpatient services. Improper payments range from reimbursement for services provided with inadequate documentation and inadvertent mistakes to outright fraud and abuse. Expenditures for inpatient services, including those provided by inpatient hospitals and skilled nursing facilities, account for one-third of all Medicare expenditures (19). The OIG has uncovered problems with hospitals taking advantage of enhanced payment by manipulating billing; hospitals reporting inaccurate wage data, which affects future Medicare payments; and inpatient facilities that may be gaming prospective payment reimbursement systems by discharging or transferring patients to other facilities for financial rather than clinical reasons. Similarly, the OIG also has identified vulnerabilities related to multiple services provided by physicians and other health care professionals, including services related to advanced imaging, pain management, and mental health. Approximately 80% of the OIG's resources are dedicated to promoting the efficiency and effectiveness of Medicare and Medicaid programs and protecting these programs and their beneficiaries from fraud and abuse.

With 1,500 employees and law enforcement agencies, the OIG's investigative receivables averaged \$2.04 billion and its audit disallowances resulting from

Medicare and Medicaid oversight averaged \$1.22 billion per year from 2006 to 2008. This resulted in a Medicare-and Medicaid-specific return on investment for OIG oversight of \$17 to \$1 (19). Further, in fiscal year 2008, implemented OIG recommendations resulted in \$16.72 billion in savings and funds put to better use. Further, the government's enforcement efforts in fiscal year 2008 resulted in 455 criminal actions against individuals or entities that engaged in crimes against department programs and 337 civil actions, which included False Claims Act and unjust enrichment lawsuits filed in federal district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters (19). Further, in 2008, the OIG excluded 3,129 individuals and entities for fraud or abuse that affected federal health care programs and/or beneficiaries.

Of course, fraud and abuse is not limited to interventional pain management with the OIG demonstrating egregious fraud by unscrupulous providers. For example, 31% of durable medical suppliers didn't even maintain physical facilities or were not open and staffed. Similar results were obtained in 2008 in Los Angeles County in 13% of the suppliers. Fraud also has been reported with infusion clinics, consequently recovery audit contractor (RAC) programs have been established which are expected to yield significant savings and also reduce fraud and abuse (23,24).

The FBI is also actively involved as the investigative agency in the fight against health care fraud, with jurisdiction over both the federal and private insurance programs. The FBI collaborates with DHHS, OIG, the FDA, Drug Enforcement Agency (DEA), Defense Criminal Investigative Service, Office of Personnel Management, IRS, and various state and local agencies. On the private side, the FBI is actively involved with national groups, such as National Health Care Anti-Fraud Association, the Blue Cross and Blue Shield Association, the American Association of Retired Persons, and the Coalition Against Insurance Fraud, as well as many other professional and grass roots efforts to expose and investigate fraud within the system. Over the years, FBI national initiatives have addressed fraud involving medical transportation, durable medical equipment, hospital cost reporting, outpatient surgery centers, pharmaceutical fraud, and a variety of other specialized investigations. The FBI fraud schemes include fraudulent billing, but also incorporate schemes such as unnecessary surgeries, diluted cancer drugs, and fraudulent lab tests (25,26).

1.2 Interventional Pain Management

Friedly et al (27) documented that between 1994 and 2001, there was a 271% increase in lumbar epidural steroid injections and a 231% increase in facet joint injections. They also showed that the total inflation adjusted reimbursement costs for lumbosacral injections increased from \$24 million to over \$175 million. Manchikanti et al (4-9,28,29), in multiple publications, have shown an increase in interventional techniques. In fact, in a recent publication (8) they showed an overall increase of IPM services of 197% compared to an increase of 137% in patients utilizing IPM services from 1997 to 2006. There was wide variation in multiple aspects. The majority of increases were attributed to the exponential growth in the performance of facet joint interventions. There was a 13.9-fold difference in the increase between the state with the lowest rate and the state with the highest rate in the utilization patterns of interventional techniques with California having the lowest rate of 37% vs. Connecticut with the highest rate of 514% and with an 11.6-fold difference between Florida and California.

An OIG report in September 2008 (10), stated that Medicare paid over \$2 billion in 2006 for interventional pain management procedures. This report also showed that from 2002 to 2006, the number of Medicare claims for facet joint injections increased by 76%. Payments for facet joint injections increased from \$141 million in 2002 to \$307 million in 2006, representing both physician and facility payments. A number of investigations by the FBI and the OIG have found inappropriate activity related to interventional techniques (23).

Expenditures in managing spinal pain are not only substantial but are increasing and the treatment modalities are controversial, as evidenced by a wide variability in the treatment methods used and alleged lack of evidence of efficacy (27,30-33). However, interventional pain procedures and even some of the spinal techniques may be supported by the fact that Freburger et al (34) showed an annual increase of 13.5% in chronic low back pain and attributed a substantial portion of the rising low back pain care costs for the past 2 decades to the rising prevalence.

Interventional techniques for the treatment of spinal pain are commonly used (4-10,35-61). Figure 2 illustrates growth patterns of interventional techniques.

2.0 MEDICAL NECESSITY

Medical necessity requires appropriate diagnosis and coding by the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) to justify services rendered and indicates the severity of a patient's condition (62). The Balanced Budget Act (HR 2015, Section 4317) requires all physicians to provide diagnostic information for all Medicare/Medicaid patients starting from January 1, 1998 (2,63). Physicians are required to code by listing the ICD-9-CM diagnostic codes shown in the medical record to be chiefly responsible for the services provided. Coding should be to the highest degree of certainty for each encounter. Medical necessity is defined in numerous ways (64-68):

- ◆ *Black's Dictionary of Law* (67) defines medical necessity as, "an absolute physical necessity, an inevitability, or convenient, useful, appropriate, suitable, proper or conducive to the end sought."
- ◆ The CMS (66) defines medical necessity in these terms: "no payment may be made under Part A or Part B for any expense incurred for items or services which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a participant."
- ◆ The AMA (68) defines medical necessity as, "health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
 - In accordance with generally accepted standards of medical practice.
 - Clinically appropriate in terms of type, frequency, extent, site, and duration.
 - Not primarily for the convenience of the patient, physician, or other healthcare provider."
- ◆ Quinn (64) defines medical necessity as: "...the shortest least expensive, or least intense level of treatment, care or service rendered, or supply provided, as determined to the extent required to diagnose or treat an injury or sickness."
- ◆ One insurer defines medical necessity as "health care services and supplies which are determined by the carrier to satisfy all of the following requirements:
 - Necessary to meet basic health needs of the Covered Person

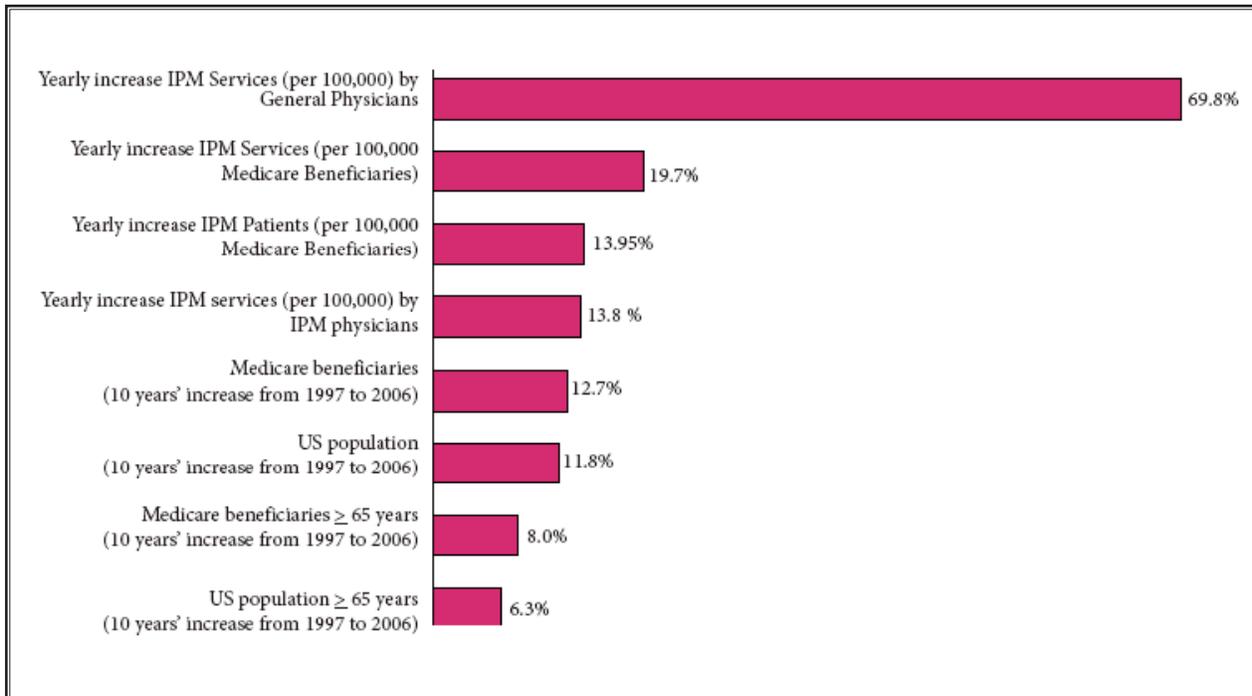


Fig. 2. Illustration of overall growth patterns (percent) from 1997 to 2006 in Medicare beneficiaries.

Adapted from Manchikanti L et al. Analysis of growth of interventional techniques in managing chronic pain in the medicare population: A 10-year evaluation from 1997 to 2006. *Pain Physician* 2009; 12:9-34 (8).

- Rendered in the most cost-effective manner and type of setting appropriate for the delivery of the service or supply
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the company
- Consistent with the diagnosis of the condition
- Required for reasons other than the convenience of the Covered Person or his or her Physician
- Demonstrated through prevailing peer-reviewed medical literature to be either:
 - Safe and effective for treating or diagnosing the condition or illness for which their use is proposed or
 - Safe with promising efficacy
- For treating a life-threatening illness or condition
- In a clinically controlled research setting
- Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health (NIH).
- ♦ Another insurer defines medical necessity as: "...the shortest, least expensive, or least intense level of treatment, care, or service rendered, or supply provided, as determined by us, the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the insured person's medical condition, is known to be safe and effective by most doctors who are licensed to treat the condition at the time the service is rendered, and is not provided primarily for the convenience of the insured person or doctor.

3.0 WIDE ARENA OF DOCUMENTATION

Federal, state, third party payor, and managed care plans rely heavily on provider documentation when assessing the claims for various parameters. These include:

- ◆ Was the billed service actually rendered or provided to the patient?
- ◆ Was the level of service or extent of the service accurately reported?
- ◆ Was the service or procedure medically necessary?
- ◆ Was the claim sent to the correct primary insurer for the service or procedure performed?

3.1 Medical Record

A medical record is a document with confidential information that functions as a clinical record and a business record. The medical record (Table 2) facilitates various functions (69-74):

- ◆ The ability of a physician and other health care professionals to evaluate and plan patients' treatment and to monitor their health care over a period of time.
- ◆ Communication and continuity of care among physicians and other health care professionals involved in patients' care.
- ◆ Accurate and timely claims review and payment.
- ◆ Appropriate utilization review and quality of care evaluations.
- ◆ Collection of data that may be useful for research and education.

The typical information for an interventional pain management medical chart (electronic and/or hard copy) is as follows:

- ◆ Patient demographic data
 - Medical insurance card copy
 - Patient's driver license copy
 - Patient guarantee and authorization forms
 - Advanced beneficiary note
- ◆ Summary sheet with problems and medication history
- ◆ Patient questionnaires
- ◆ Initial evaluation
- ◆ Progress notes
- ◆ Laboratory test results
 - Radiographic evaluation results
 - Results of various medical tests
- ◆ Medical records from other providers
 - Facility notes
 - Consultation reports

- Correspondence

Documentation outside the patients' medical record in another format may include multiple items such as encounter forms or super bills or charge sheets, physician orders, prescription refill logs, records of laboratory test orders, managed care referral forms, patient account records, copies of explanation of benefits, and other records. In a criminal investigation related to fraud and abuse, similar to medical liability litigation, the definition of documentation is taken, at times out of context, much further than a patient's medical record and may include multiple items such as various notes and internal memoranda not intended for inclusion into the patient medical records and not intended for external disclosure, appointment schedules, surgery schedules, appointment calendars, work planners, travel logs and records, and telephone message logs.

3.2 Documentation Standards

Simple, yet extremely important standards of documentation must be followed.

- ◆ Medical records must be legible.
 - All entries must be dated with month, day, and year.
 - Every page in the chart should be patient-identified.
 - Medical records should always be documented in permanent ink (not with pencil).
 - Summary sheet should have identifying information, height, weight, medication list, previous surgeries, and diagnosis.
 - All telephone calls must be documented.
 - All documents contained inside the chart should belong to that particular patient.
- ◆ All additions and corrections should be documented clearly with date and signature.
 - Incorrect entries should be crossed out with a single line with rewriting of the correct entry.
 - The credibility of notes written more than 24 to 48 hours after the care was rendered is considered suspect.
- ◆ Document all health risk factors, including allergies and adverse reactions to medications, foods, or other substances.
 - Document that sufficient information was provided with samples and prescriptions.
 - Medical necessity for all diagnostic services or tests and for all procedures and interventions must be established.

- Documentation of follow-up treatment dates for coordination of services and of the time for services based on time is crucial.

3.3 Documentation Process

A multitude of personnel associated with a practice or a facility are responsible for documentation. They include physician assistants, nurse practitioners, clinical nurse specialists, physical therapists, psychologists, nurses, and medical assistants who obtain patient histories and vital signs, administer injections, and otherwise provide certain restricted services.

To meet the entire documentation criteria, the following checklist must be utilized.

- ◆ Authorization for making entries and policies should be defended.
- ◆ Support the medical necessity of the service performed.
- ◆ Provide a clear description of the procedure or service including technique and end results.
- ◆ Make it clear that the procedure was performed by the reporting or billing physician.
- ◆ Document appropriate and specific diagnostic code as ICD-9 CM diagnostic code.
- ◆ Provide documentation of indications and medical necessity, which may be reviewed by payors at any time.
- ◆ Follow correct coding initiatives and Local Coverage Determinations (LCDs) with the limitations, which become part of documentation.

3.4 Electronic Documentation

The evolution of medical records from paper to electronic changes the work processes for seeing a patient, for storing information, for accessing information, and the look of the output when the note is printed. However, using EHR or EMR does not change the duty to comply with the basic medical record guidelines. Some of the issues such as legibility, storage in one place, locking the records in the office at night, and off-site access become non-issues.

3.5 Types of Documentation

Documentation includes evaluation and management services and interventional techniques. Documentation for interventional techniques may vary based on whether the procedure was performed in a facility setting such as hospital outpatient department or ambulatory surgery center versus in a physician's office.

4.0 EVALUATION AND MANAGEMENT SERVICES

Evaluation of a patient is an integral part of interventional pain management. The last few years have seen significant confusion over the proper documentation for evaluation and management services in general and for interventional pain management in particular.

In the past, physicians followed a simple format characterized by the acronym SOAP, which stands for subjective, objective, assessment, and plan. This was later expanded, presumably to meet the criteria of CMS's evaluation and management services, to SOAPER to also include education and return instructions. Other variations of the same theme include SOAPIE, which stands for subjective, objective, assessment, plan, intervention, and evaluation; and SNO-CAMP, which stands for subjective, nature of presenting problem, counseling, assessment, medical decision making, and plan. However, owing to the complicated nature of the documentation guidelines proposed by the CMS, SOAP and its variations no longer meet the criteria in most cases.

4.1 Levels of Service

Evaluation and management services in pain management are office outpatient services and hospital inpatient services (Table 3). Five levels for consultations and new patient visits include (66,74):

Level 1: Problem focused

Level 2: Expanded problem focused

Level 3: Detailed/low complexity

Level 4: Comprehensive/moderate complexity

Level 5: Comprehensive/high complexity

Table 4 illustrates shifting level of services and utilization over the years. Table 5 illustrates the effect on reimbursement of utilization under the Sustained Growth Rate (SGR) formula.

4.2 The Different Aspects of Consultation and Visit

Interpretation of the guidelines for consultations versus visits and billing for these services, along with the level of service, are contentious issues. Guidelines by the CMS have clarified some of the issues involved in the confusion with regard to this issue. The guidelines suggest that any time a physician sees a patient at the request of another physician, the visit may be a consultation (66,71-73,75,76). However, 4 Rs must be considered for the visit to qualify for a consultation.

- ◆ Request and Reason: A request and reason for the consultation. The requesting physician must be seeking the advice or opinion of the consulting physician, not transferring care. Documentation of such a request and reason for consultation is essential in the requesting physician’s plan of care in the patient’s medical record.
- ◆ Render: The physician must render the evaluation. The physician must provide an opinion or advice regarding the evaluation and/or management of a specific problem as requested by another physician.
- ◆ Report: A written report with the consultant’s findings and recommendations shall be provided to the referring physician.
The intent of a consultation service is that a physician is asking another physician for advice, an opinion, a recommendation, a suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific

Table 2. *Functions and requirements of patient’s medical record.*

Clinical Record	Business Record	CMS’s Requirements
Indicates quality of care	Supports insurance billing	Supports “medical necessity”
Promotes continuity of care among physicians	Facilitates claim review	Complete
Provides clinical data for research	Reduces audit exposure	Legible
Provides clinical data for education	Reduces professional liability exposure	Signed

Table 3. *Categories and subcategories of levels of service.*

A. Office or Other Outpatients	
i. New Patient	
99201 – Problem-Focused, Straightforward	99223 – Comprehensive, High Complexity
99202 – Expanded-Problem-Focused, Straightforward	ii. Subsequent Hospital Care
99203 – Detailed, Low Complexity	99231 – Problem-Focused, Low Complexity
99204 – Comprehensive, Moderate Complexity	99232 – Expanded-Problem-Focused, Moderate Complexity
99205 – Comprehensive, High Complexity	99233 – Detailed, High Complexity
ii. Established Patient	iii. Observation or Inpatient Care
99211 – Brief	99234 – Detailed or Comprehensive, Low Complexity
99212 – Problem-Focused, Straightforward	99235 – Comprehensive, Moderate Complexity
99213 – Expanded-Problem-Focused, Straightforward	99236 – Comprehensive, High Complexity
99214 – Detailed, Moderate Complexity	iv. Initial Inpatient Consultation (New or Established)
99215 – Comprehensive, High Complexity	99251 – Problem-Focused
iii. Office Consultation (New or Established Patient)	99252 – Expanded-Problem-Focused
99241 – Problem-Focused, Straightforward	99253 – Detailed, Low Complexity
99242 – Expanded-Problem-Focused, Straightforward	99254 – Comprehensive, Moderate Complexity
99243 – Detailed, Low Complexity	99255 – Comprehensive, High Complexity
99244 – Comprehensive, Moderate Complexity	C. Emergency Department Services
99245 – Comprehensive, High Complexity	i. New or Established Patient
B. Inpatient Hospital Services	99281 – Problem-Focused, Straightforward
i. Initial Inpatient (New or Established Patient)	99282 – Expanded-Problem-Focused, Low Complexity
99221 – Detailed, Low Complexity	99283 – Expanded-Problem-Focused, Moderate Complexity
99222 – Comprehensive, Moderate Complexity	99284 – Detailed, Moderate Complexity
	99285 – Comprehensive, High Complexity

Table 4. Distribution across levels of new outpatient visits for office visits, established visits, and outpatient consultations for Medicare beneficiaries.

Type of Service	HCPSC	FY 2002	FY 2003	FY 2004	FY2005	FY2006	FY2007
New Outpatient Visits	99201	4.6%	4.0%	3.5%	3.5%	3.1%	2.9%
	99202	24.2%	22.9%	21.4%	21.3%	20.4%	19.9%
	99203	38.4%	39.4%	40.8%	40.8%	41.6%	42.3%
	99204	24.0%	24.7%	25.8%	25.8%	26.2%	26.4%
	99205	8.9%	9.0%	8.5%	8.6%	8.6%	8.5%
	Total	12,477,711	12,250,857	11,754,918	12,589,773	12,332,344	12,201,402
Established Patients	99211	5.8%	6.0%	4.8%	4.8%	4.7%	4.5%
	99212	14.7%	13.3%	11.7%	11.8%	11.0%	10.4%
	99213	54.0%	53.2%	52.1%	52.1%	50.9%	50.0%
	99214	22.4%	24.4%	27.9%	27.9%	29.8%	31.3%
	99215	3.1%	3.2%	3.4%	3.4%	3.7%	3.9%
	Total	199,913,590	205,785,385	200,162,523	210,666,797	208,269,010	206,402,270
Outpatient Consultations	99241	3.9%	3.4%	2.8%	2.8%	2.5%	2.2%
	99242	13.4%	12.6%	11.4%	11.4%	10.7%	10.0%
	99243	33.0%	33.2%	33.2%	33.1%	33.0%	32.9%
	99244	35.7%	36.5%	38.2%	38.2%	39.1%	39.9%
	99245	13.9%	14.3%	14.4%	14.5%	14.7%	14.9%
	Total	12,991,580	13,705,890	14,419,982	15,296,970	15,326,615	15,149,493

Source: Specialty Utilization data files from CMS: www.cms.hhs.gov (78).

Table 5. Minor procedures that contributed to the total increase in spending.

Code	Description	2005 Charges (in millions)	Increase In Services	Increase In Charges	Percentage of Total SGR Spending	Contribution to Total Increase in SGR Spending
97110	Therapeutic exercises	\$1,001	25.7%	23.5%	1.06%	0.25%
97140	Manual therapy	\$377	32.1%	32.9%	0.40%	0.13%
97112	Neuromuscular reeducation	\$164	37.3%	41.6%	0.17%	0.07%
64475	Lumbar facet joint nerve block	\$77	30.0%	68.2%	0.08%	0.06%
20610	Drain/inject, joint/bursa	\$273	15.5%	17.9%	0.29%	0.05%
17304	1 stage mohs, up to 5 spec	\$242	16.5%	19.7%	0.26%	0.05%
64483	Lumbar foramen epidural	\$108	26.8%	36.2%	0.11%	0.04%
97530	Therapeutic activities	\$194	15.0%	19.0%	0.21%	0.04%
11721	Debride nail, 6 or more	\$268	5.9%	11.0%	0.28%	0.03%
	<i>Other Minor Procedures</i>	\$3,644	23.0%	9.9%	3.86%	0.38%
Total	All Minor Procedures	\$6,351	23.4%	15.6%	6.72%	1.05%

Source: Kuhn HB. (Letter) Department of Health and Human Services, Centers for Medicare and Medicaid Services. To Glen Hackbarth, Chair, Medicare Payment Advisory Commission. April 7, 2006

medical area beyond the requesting professional's knowledge. A physician may initiate diagnostic services and treatment at the initial consultation service or subsequent visit. Ongoing management following the initial consultation service by the consultant physician must be reported using the subsequent follow-up visit codes.

Table 6 shows the differences between a consultation and visit. One of the major requirements of a consultation is that of documentation in the patient's record that the consultation in fact was requested. This can be accomplished by a letter from the requesting physician asking for the consultation or by a consultation request slip followed by documentation by the consulting physician (something similar to "I was asked to see this patient for consultation by Dr. Smith"). Documentation that findings of the consulting physician were communicated in writing to the requesting physician is also crucial. This may be accomplished by sending the requesting physician a copy of the patient record and a thank-you letter. Unfortunately, published guidelines require that it be in writing, contradicting the earlier guidelines under which communication by telephone was sufficient. Thus, the initial request may be a verbal interaction between the requesting physician and the consulting physician. However, the verbal

conversation should be documented in the patient's medical record indicating a request for a consultation service was made by the requesting physician or qualified non-physician practitioner (77).

Coding for a large number of consultations raises red flags to the CMS medical directors who are monitoring each physician's coding profile. Thus, abnormal coding profiles are likely to bring on audits. Therefore, interventional pain management specialists must weigh the increased revenue from a consultation versus the possible consequences of an audit, which may not only include the evaluation and management services but also extend to any other area of the practice. The patterns of consultations and visits for pain management services are illustrated in Tables 7 and 8. These services are calculated only for physicians designated as pain management (-72) or (-09) in the Medicare population (78). As shown in Table 7, there were no significant differences for outpatient office visits. However, with outpatient consultations there was a shift in the coding patterns. Level 2 consultation services (99242) decreased from 9.3% in 2002 to 5.1% in 2007, while Level 3 consultation services decreased from 39% in 2002 to 31.8% in 2007. In contrast, Level 4 consultation services increased from 37.5% in 2002 to 50.1% in 2007. For both types, Level 5 services ranged

Table 6. CMS guidelines differentiating features of consultation and a referral visit.

	Consultation	Referral Visit
1. Problem	Suspected	Known
2. Request language	"Please examine patient and provide me with your opinion and recommendation on his/her condition."	"Patient is referred for treatment or management of his/her condition."
3. Request	Written request for opinion or advice received from attending physician, including the specific reason the consultation is requested.	Patient appointment made for the purpose of providing treatment or management or other diagnostic or therapeutic services.
4. Report language	"I was asked to see Mr. Jones in consultation by Dr. Johnson."	"Mr. Jones was seen following a referral from Dr. Johnson."
5. Patient care	Only opinion or advice sought. Subsequent to the opinion, treatment may be initiated in the same encounter.	Transfer of total patient care for management of the specified condition.
6. Treatment	Undetermined course	Prescribed and known course
7. Correspondence	Written opinion returned to attending physician.	No further communication (or limited contact) with referring physician is required.
8. Diagnosis	Final diagnosis is probably unknown.	Final diagnosis is typically known at the time of referral.
9. Follow-up	Patient advised to follow up with attending physician.	Patient advised to return for additional discussion, testing, treatment, or continuation of treatment and management.
10. Further follow-up	Confirmatory or follow-up consultation or established patient based on specific situation.	Always established patient for 3 years.

around 10% for office outpatient visits and 12% for outpatient consultations.

As illustrated in Table 8, for established patients for office visits, there was no significant change noted in Level I, III, and V services. However, Level II services in 2002 constituted 23.1%, while they decreased to 12.4% in 2007. Further, in 2002, Level IV services were offered for 15.3% of patients, while they increased to 25.6% in 2007.

4.3 Key Elements of Service

To determine the appropriate level of service for a patient's visit, it is necessary to first determine whether the patient is new or already established. The physician

then uses the presenting illness as a guiding factor in his or her clinical judgement about the patient's condition to determine the extent of key elements of service to be performed. The key elements of service include history, examination, and medical decision making.

4.3.1 History

History constitutes one of the 3 crucial components of evaluation and management, the other 2 being physical examination and medical decision making. All patients, whether new or established, seen in the office or in the hospital setting, for visits or consultation, require documentation of history based on level of service. The history includes:

Table 7. *Patterns of consultations and new outpatient visits for pain management services.*

HCPCS	2002	2003	2004	2005	2006	2007
New Outpatient Visits						
99201	1.8%	1.7%	1.7%	1.6%	1.5%	1.4%
99202	9.4%	7.8%	6.8%	6.7%	6.8%	6.0%
99203	41.6%	42.9%	42.1%	42.0%	42.8%	40.9%
99204	38.2%	37.1%	38.8%	39.0%	38.8%	42.6%
99205	9.0%	10.6%	10.8%	10.7%	10.1%	9.1%
Total	22,265	43,450	73,157	78,992	85,908	98,995
Outpatient Consultations						
99241	2.8%	3.2%	1.9%	1.8%	1.2%	0.9%
99242	9.3%	7.5%	5.3%	5.2%	4.6%	5.1%
99243	39.0%	35.6%	34.9%	34.7%	34.1%	31.8%
99244	37.5%	40.7%	45.6%	45.7%	47.5%	50.1%
99245	11.4%	13.1%	12.3%	12.5%	12.7%	12.1%
Total	20,138	41,517	78,467	85,504	90,447	95,002

Source: Specialty Utilization data files from CMS: www.cms.hhs.gov (78).

Table 8. *Office or other outpatient follow-up visits.*

HCPCS	2002	2003	2004	2005	2006	2007
Established Patient Visits						
99211	5.7%	4.2%	5.2%	5.3%	5.0%	4.3%
99212	23.1%	20.6%	16.2%	16.1%	14.2%	12.4%
99213	53.8%	54.5%	54.7%	54.7%	55.1%	55.5%
99214	15.3%	18.6%	21.4%	21.5%	23.6%	25.6%
99215	2.1%	2.1%	2.4%	2.1%	2.1%	2.1%
Total	142,025	326,531	677,995	730,224	846,498	995,834

Source: Specialty Utilization data files from CMS: www.cms.hhs.gov (78).

- ◆ 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 presenting problem of the patient (Table 9). Nevertheless, the required documentation is progressively detailed and complex, ranging from brief and problem-pertinent for problem-focused and extended-problem-focused to extended and complete for detailed comprehensive and comprehensive/complex services.

4.3.1.1 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, progress note, and consultation report.

4.3.1.2 History of Present Illness

History of present illness is a chronological description 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 (2,3,66,71-73). A brief history of the present illness requires documentation of one to 3 elements of the present illness, whereas extended history of present illness requires documentation of at least 4 elements of the history of the present illness or the status of at least 3 chronic or inactive conditions. Further, a brief history of the present illness suffices for problem-focused and expanded-problem-focused visits, whereas an extended history is required for detailed comprehensive and comprehensive complex levels of services (2,3,66,71-73).

4.3.1.3 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 (2,3,66,71-73).

4.3.1.4 Past, Family, and Social History

The past, family, or social history consists of:

- ◆ 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 appropriate for age reflecting past and current activities.

Table 9. Documentation of level of history.

	Problem-Focused	Expanded Problem	Detailed	Comprehensive
Chief complaint	Yes	Yes	Yes	Yes
History of present illness	Brief (1-3)	Brief (1-3)	4 elements or > 3 chronic conditions	4 elements or > 3 chronic conditions
System review	NA	Problem pertinent (1 system)	Extended (2-9 systems)	Complete (10+ systems)
Past, family, social history	NA	NA	Pertinent (1 area)	Complete (2 or 3 areas)

4.3.2 Physical Examination

Various levels of evaluation and management services are based on 4 types of examination (Table 10). However, the type of examination is dependent on the nature of the presenting problem and clinical judgment of the physician.

- ◆ Problem-focused: A limited examination of the affected body area or organ system; includes examination of 1 to 5 bullet-point elements from a single-system examination, such as musculoskeletal.
- ◆ Expanded problem-focused: A limited examination of the affected body area or organ system and any other symptomatic or related body areas or organ systems; documentation of at least 6 of the bullet-point elements from one of the 10 single-organ system examinations.
- ◆ Detailed: An extended examination of the affected body area or organ system and any other symptomatic or related body area or organ system; documentation of at least 12 bullet points or elements from one of the 10 single-system examinations.
- ◆ Comprehensive: A general multisystem examination; a complete examination of a single organ system and other symptomatic or related areas or organ systems; documentation of all elements identified by a bullet.

The content in documentation requirements for each type and level of examination are summarized and described in Table 10.

4.3.2.1 General Multisystem Examination

General multisystem examinations, although they appear simpler and may fit universal needs, are somewhat complex. To qualify them for a given level of multisystem examination, the documentation should include:

- ◆ Problem-focused examination: Should include performance and documentation of one to 5 el-

ements in one or more organ systems or body areas.

- ◆ Expanded-problem-focused: Should include performance and documentation of at least 6 elements in one or more organ systems or body areas.
- ◆ Detailed examination: Should include at least 6 organ systems or body areas for each system or area selected; performance and documentation of at least 2 elements is expected. However, alternatively, a detailed examination may include performance and documentation of at least 12 elements in 2 or more organ systems or body areas.
- ◆ Comprehensive: Comprehensive examinations should include at least 9 organ systems or body areas. For each system or area selected, all elements of the examination should be performed unless specific directions limit the content of the examination. For each area or system, documentation of at least 2 elements identified by a bullet is expected.

Even though criteria can be met by examining each area or system and documenting at least 2 elements, the difficulties with general multisystem examination include:

- ◆ Ophthalmoscopic examination of the optic discs and posterior segments.
- ◆ Otoscopic examination of the external auditory canals and tympanic membranes.
- ◆ Inspection and palpation of breasts.
- ◆ Examination of the genitourinary system.

However, comprehensive examination can be met by examination of only 9 of 12 organ systems or body areas.

4.3.3 Medical Decision Making

Documentation of the complexity of medical decision making involves 4 types of medical decision-making to accommodate all levels of evaluation and

Table 10. Requirements for various levels of physical examination.

	Problem-Focused	Expanded Problem-Focused	Detailed	Comprehensive
Multisystem	Perform and document 1–5 elements	Perform and document > 6 elements	Perform and document 12 elements in > 2 areas	Perform all elements in > 9 areas. Document > 2 elements in 9 areas
Single system	Perform and document 1–5 elements	Perform and document > 6 elements	Perform and document 12 elements	Perform all elements. Document every element in shaded box and > 1 element in unshaded box.

management services. The 4 types of medical decision-making options include:

- ◆ Straightforward
- ◆ Low complexity
- ◆ Moderate complexity
- ◆ High complexity

Medical decision making refers to the complexity of establishing a diagnosis or selecting a management option (or both) as measured by three components:

- ◆ Diagnosis-management options, with number of possible diagnoses or the number of management options.
- ◆ Review of records-investigations, with number or complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed.
- ◆ Risks of significant complications, morbidity, and mortality and comorbidities associated with the patient's presenting problem, the diagnostic procedures, and the possible management options.

The progression of elements required for each level of medical decision making is listed in Table 11. To qualify for a given type of decision making, at least 2 of the 3 elements listed must be either met or exceeded.

4.3.3.1 Diagnosis or Management Options

The number of possible diagnoses or the number of management options (or both) 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 a physician (Table 12). The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses (Table 13). Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need for further consultations or advice from others is another indicator of the complexity of diagnostic or management problems.

Required documentation of REVIEW or ORDER (or both) of diagnostic testing and reporting is as follows:

- ◆ Clinical laboratory tests
- ◆ Radiology (review of reports or interpretation)
- ◆ Medical diagnostic tests
- ◆ Any discussion with interpreting physician
- ◆ Old record request
- ◆ Review of records

Following are some important aspects in documenting diagnosis or management options (or both).

- ◆ 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 or further evaluation.
- ◆ For a presenting problem with an established diagnosis, the records should reflect whether the problem is improved, well-controlled, resolving, or resolved or is 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 differential diagnosis or as a possible, probable, or rule-out diagnosis.
- ◆ The initiation of, or changes in, treatment should be documented.
- ◆ The treatment includes a wide range of management options, including patient instructions, nursing instructions, therapies, and medications.
- ◆ If referrals are made, consultations are requested, or advice is sought, they must be indicated on the record with details as to whom or where the referral or consultation is made.

4.3.3.2 Review of Records and Investigations

The nature, amount, and complexity of data to be reviewed are based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records or obtain history from sources other than the patient increases the amount and com-

Table 11. *Elements of decision making.*

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

plexity of data to be reviewed.

Amount and complexity of data reviewed and points for each activity are as follows:

Categories of Data to be Reviewed Points
 Review or order clinical tests..... 1
 Review or order of tests in the radiology section of CPT..... 1
 Review or order of tests in the medicine section of CPT..... 1
 Discussion of test results with performing physician 1
 Decision to obtain old records or history from someone other than patient 1
 Review and summarization of old records or obtaining history from someone other than patient and discussion of case with another health provider 2
 Independent visualization of image, tracing, or specimen itself (not simply review of report)..... 2

4.3.3.3 Risks

The risks of significant complications, morbidity, or mortality are based on the risks associated with:

- ◆ The presenting problem
- ◆ The diagnostic procedure
- ◆ Possible management options

Some important aspects of the risks in interventional pain management are:

- ◆ Comorbidity, underlying disease, or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, or mortality should be documented.
- ◆ Planned or scheduled invasive diagnostic or therapeutic procedures or surgical procedures at the time of the encounter should be documented, with the type of procedure.
- ◆ If an invasive diagnostic, therapeutic, or surgical procedure is performed at the time of the encoun-

ter, the specific procedure should be documented.

- ◆ If the patient is referred for an emergency or invasive diagnostic, therapeutic procedure, or surgical intervention, such referrals should be documented.

Table 12 shows some salient aspects in the determination of risks, whether minimal, low, moderate, or high. However, the determination of risks is complex and not readily quantifiable in low back pain evaluation and is also variable with each specialty. In addition, the assessment of risk of the presenting problems is based on the risks related to the disease process anticipated between the immediate and the next encounter. The assessment of risk of selecting diagnostic procedures and management options is also based on the risk during and immediately after any procedures or treatments. The highest level of risk in any one category of the 3 described determines the overall risks. Table 13 shows risk of complications or mortality-morbidity relevant to interventional pain management.

4.3.3.4 Counseling or Coordination of Care

If either counseling or coordination of care dominates the physician-patient or family encounter (face-to-face time in the office or other outpatient setting exceeding 50% of the time), time is considered the key or controlling factor to qualify for a particular level of evaluation and management service.

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

4.3.4 Summary Requirements

Table 14 shows an abbreviated summary of the process and requirements for various levels of service in multiple categories.

Table 12. *Illustration of risk based on the diagnosis and/or management options, amount and/or complexity of data to be reviewed, risk of complications, and type of decision-making.*

Risk of complications or morbidity or mortality	Number of diagnosis or management options	Amount or complexity of data to be reviewed	Type of decision making
Minimal	Minimal 1	Minimal or low 1	Straightforward
Low	Limited 2	Limited 2	Low complexity
Moderate	Multiple 3	Moderate 3	Moderate complexity
High	Extensive 4	Extensive 4	High complexity

Table 13. *Risk of complications or morbidity-mortality.*

Level of Risk	Presenting Problem	Diagnostic Procedure Ordered	Management Option Selected
Minimal	One self-limited or minor problem (e.g., postprocedure follow-up, postprocedure pain)	Laboratory tests requiring venipuncture Single area X-rays, CT, MRI without contrast	Rest Elastic bandages Over-the-counter drugs
Low	Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated illness or injury, simple sprain (myofascial syndrome, intra-articular disorders synovitis)	CT with contrast MRI with contrast	Over-the-counter drugs Physical therapy Occupational therapy Psychotherapy Interventional procedures with no identified risk factors (trigger point injections)
Moderate	One or more chronic illness with mild exacerbation (chronic low back pain) Two or more stable chronic illnesses (chronic low back pain, neck pain, headache) Acute illness with systemic symptoms (discitis, epidural abscess) Acute complicated injury (disc herniation) Undiagnosed new problem	Obtain fluid from body cavity (e.g., joint, lumbar puncture)	Interventional procedures with identified risk factors Elective major surgery (percutaneous or endoscopic) Prescription drug management
High	One or more chronic illnesses with severe exacerbation Acute or chronic illness or injuries that pose a threat to life or bodily function (e.g., acute MI, pulmonary embolus, progressive rheumatoid arthritis, psychiatric illness with threat to self or others, acute renal failure, severe respiratory distress) Abrupt change in neurological status (e.g., weakness, sensory loss, TIA, cauda equina syndrome)	Discography Myelography	Elective major surgery (percutaneous or endoscopic) with identified risk factors Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Do not resuscitate

5.0 DOCUMENTATION OF INTERVENTIONAL PROCEDURES

All interventional techniques are considered surgical procedures. Documentation requirements are as follows:

- ◆ History and physical
- ◆ Indications and medical necessity
- ◆ Intra-operative procedural description
- ◆ Post-operative monitoring and ambulation
- ◆ Discharge/disposition

5.1 History and Physical

The physician's history should include the following elements:

- ◆ Documentation of the signs and symptoms warranting the interventional procedure.
- ◆ A listing of the patient's current medications including dosages, route, and frequency of admission.
- ◆ Any existing co-morbid conditions and previous surgeries.
- ◆ Documentation of any social history or conditions which would have an impact on the patient's care upon discharge from the facility following the procedure.

The physician's physical examination should not only reflect the interventional procedure, but also the type of anesthesia planned. Generally, for interventional techniques, if no anesthesia is to be administered,

Table 14. Illustration of CMS requirements for various levels of service.

Type of Visit	Documentation of History				Physical Examination		Complexity of Decision Making
	Chief Complaint	History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and Social History (PFSH)	General Multisystem	Single System	
Problem-Focused Level 1	✓	<u>Brief</u> One to 3 elements	NA	NA	<u>Limited</u> to affected body areas one to 5 elements	<u>Limited</u> to affected body areas one to 5 elements	Straightforward
Expanded Problem-Focused Level 2	✓	<u>Brief</u> One to 3 elements	<u>Problem Pertinent</u> Positives and Negatives	NA	<u>Limited</u> to symptomatic or related systems\ 6 elements	<u>Limited</u> to symptomatic or related systems 6 elements	Straightforward
Detailed Level 3	✓	<u>Extended</u> At least 4 elements or status of 3 chronic or inactive conditions	<u>Extended</u> Positive and Pertinent negatives 2 to 9 systems	<u>Pertinent</u> To problems identified in HPI	<u>Extended</u> At least 2 elements from 6 systems or 12 in 2 or more systems	<u>Extended</u> examination of symptomatic and related systems at least 12 elements	Low Complexity
Comprehensive Level 4	✓	<u>Extended</u> At least 4 elements or status of 3 chronic or inactive conditions	<u>Complete</u> At least 10 systems	<u>Complete</u> At least one specific HPI from 3 of 3 history areas	<u>Comprehensive</u> At least 2 elements from 9 systems 18 element	<u>Complete</u> Every element in each box with a shaded border and at least one element in each box with unshaded border	Moderate Complexity
Comprehensive Complex Level 5	✓	<u>Extended</u> At least 4 elements or status of 3 chronic or inactive conditions	<u>Complete</u> At least 10 systems	<u>Complete</u> At least one specific HPI from 3 of 3 history areas	<u>Comprehensive</u> At least 2 elements from 9 systems 18 elements	<u>Complete</u> Every element in each box with a shaded border and at least one element in each box with unshaded border	High Complexity

the physical examination is limited to the assessment of the patient’s mental status and an examination specific to the proposed procedure, including any co-morbid conditions.

However, if intravenous sedation or any other type of anesthesia is planned, the physical examina-

tion should also include documentation of the results of an auscultatory examination of the heart and lungs, and an assessment and written statement about the patient’s general health, in addition to the assessment of mental status and an examination specific to the proposed procedure and any co-morbid conditions.

5.2 Indications and Medical Necessity

Medical necessity must be established for each and every procedure. In a well documented chart, an auditor or anyone reviewing the chart should be able to find indications and medical necessity for that particular procedure easily. The alternative would be a poorly documented chart, which will require one to look in multiple places for the purported indications and to determine if the procedure met medical necessity criteria. General documentation requirements for interventional techniques including both indications and medical necessity are as follows:

1. Complete initial evaluation including history and physical examination.
2. Physiological and functional assessment, as necessary and feasible.
3. Definition of indications and medical necessity, as follows:
 - Suspected organic problem.
 - Non-responsiveness to conservative modalities of treatment.
 - Pain and disability of moderate-to-severe degree.
 - No evidence of contraindications such as severe spinal stenosis resulting in intraspinal obstruction, infection, or predominantly psychogenic pain.
 - Responsiveness to prior interventions with improvement in physical and functional status for repeat blocks or other interventions.
 - Repeating interventions only upon return of pain and deterioration in functional status.

5.3 Procedural Documentation

This includes description of the procedure which entails documentation of consent, diagnosis, monitoring, sedation, positioning, site preparation, fluoroscopy, drugs utilized, needle placement, and complications. In addition, the description should also include postoperative monitoring, and finally, discharge/disposition.

Informed Consent: There should be an informed consent for all interventional techniques. This consent should describe the alternatives available and complications in detail. Generally, for interventional pain procedures, this consent must always be signed by the patient. In rare situations, another person may sign the consent for the patient.

Names of all the personnel during the procedure assisting or monitoring must be documented.

Diagnosis: The diagnosis should match the procedure performed.

Physiologic Monitoring: Appropriate and at least basic monitoring should be applied in all cases of interventional techniques if a patient is sedated. This should include at minimum, monitoring of cardiac rhythm, heart rate, blood pressure, and continuous pulse oximetry.

Description of Sedation: Type of drug, the volume, and dosage must be documented.

Patient Positioning: Positioning for each procedure or multiple procedures performed should be described in the procedure description note.

Sterile Field Preparation: The type of preparation and agent utilized should be described.

Fluoroscopic Visualization: Should include the name of the technologist and time of exposure in seconds.

Antibiotic Administration: If an antibiotic is administered prior to or during the procedure, it should be documented.

Local Anesthesia: It should be mentioned if local infiltration or anesthesia is provided.

Description of Intravenous Access: The type of intravenous access, the size of cannula, and the fluid administered must be documented.

Needle Placement: It should include the type, size, and gauge of the needle. You may also describe under fluoroscopic guidance, the direction of the needle, etc., and the final anatomic placement. This is generally performed under fluoroscopy with or without contrast injection.

Complications: Any and all complications must be described.

Condition Following the Procedure: The condition of the patient at the end of the procedure, as well as mode of transportation from the operating room to the recovery room should be documented.

Postoperative Monitoring: This should include not only the monitoring, but all the complications during the procedure or if any additional parts of the treatment are provided in this phase.

Discharge/Disposition: The discharge and disposition also should be documented appropriately, including the instructions provided to the patient.

6.0 DOCUMENTATION IN AMBULATORY SURGICAL CENTERS

Comprehensive documentation requirements for ambulatory surgical services include:

- ◆ History and physical examination documentation
- ◆ Pre-operative medical record documentation
- ◆ Anesthesia documentation
- ◆ Intra-operative medical record documentation
- ◆ Post-operative medical record documentation
- ◆ Discharge documentation

The Medicare Quality Improvement Organization (QIO) program reviews samples of Medicare cases from ambulatory surgery centers. Ambulatory surgery center charts are subjected to quality screening criteria. The subjected criteria include history and physical examination, pre-operative medical record documentation, anesthesia documentation, intra-operative documentation, and post-operative documentation, along with discharge documentation. Other carriers may also follow the same principles. Accreditation organizations do follow these criteria, specifically if they provide a deemed status.

As a rule, an appropriate history and physical examination must be completed in a timely manner, i.e., within the 30 calendar days preceding the procedure.

A history should be taken regardless of the type of anesthesia planned or given, as well as when no anesthesia is given.

However, the extent of documentation required for a physical examination reflects the type of anesthesia planned and/or given, according to the hierarchy as described.

6.1 History and Physical Examination

The federal and many state administrative regulations require the following:

- ◆ The medical record must include a history and physical examination which documents any significant medical history and results of the physical examination (1,79-81).
- ◆ The history and physical examination to be completed no more than 30 days prior to the date of surgery. *Ambulatory surgery centers may accept history and physical documents from other practitioners or organizations if the results of the history and physical are confirmed by the practitioner who is accepting responsibility for the patient's care and the practitioner documents or confirms the conclusions or impressions that were drawn from the history and physical (81).* How-

ever, any significant changes in the patient's condition subsequent to these assessments are to be documented.

- ◆ A pre-procedure note by the practitioner is to be completed on the day of the procedure, if history and physical was performed in another setting or by another provider.
- ◆ The record should always document the physician's examination of the patient, performed immediately prior to surgery (81,82).
- ◆ Statements such as "see previous record" or "same" generally are not acceptable unless a copy of the previous report is included in the current record.

6.1.1 Physician's History and Physical Examination

The physician's history should include the following:

- ◆ History of present illness: documentation of the identification and symptoms warranting the invasive procedure.
- ◆ Drug history: a listing of the patient's current medications including dosages, route, and frequency of administration.
- ◆ Medical history and review of systems: any existing comorbid conditions and previous surgeries.
- ◆ Social history: documentation of any social history or conditions which would have an impact on the patient's care upon discharge from the facility following the procedure.
- ◆ Allergies: any known allergies, including medication reactions.

The physician's physical examination should not only reflect the interventional procedure, but also anesthesia planned. The extent of documentation required in the physical examination is to be reflective of the type of anesthesia planned and/or given, according to the following hierarchy:

- ◆ If no anesthesia is to be administered or only topical or local anesthesia/regional block, there should be:
 - An assessment of the patient's mental status.
 - An examination specific to the proposed procedure specific to any co-morbid conditions.
- ◆ If the planned anesthesia includes intravenous sedation, the physical examination should include the following:
 - An assessment of the patient's mental status.
 - An examination specific to the proposed procedure and any co-morbid conditions.
 - Documentation of the results of an auscultatory examination of the heart and lungs.

- ◆ If planned anesthesia includes major anesthetic technique, general, spinal, or epidural anesthesia (not epidural or spinal as a therapeutic procedure), the physical examination should include the following:
 - An assessment of the patient’s mental status.
 - An examination specific to the proposed procedure and any co-morbid conditions.
 - Documentation of the results of an auscultatory examination of the heart and lungs.
 - Assessment and written statement about the patient’s general condition.

Thus, the level of anesthesia to be administered dictates the components of the physician’s physical examination. However, any combination of the forms of anesthesia described above would necessitate a physical examination relevant to the highest level of anesthesia planned (Table 15).

6.2 Pre-Operative Requirements

These include pre-operative, intra-operative, post-operative, anesthesia, and discharge guidelines (Table 16).

6.2.1 Pre-operative Medical Record Requirements

The medical record should contain various elements in the pre-operative record.

- ◆ Date of admission and discharge
- ◆ Names of referring and attending physicians
- ◆ The pre-operative diagnosis
- ◆ Data to support the diagnosis and planned treatment
- ◆ Reports of any pre-operative diagnostic studies or consultations

- ◆ Diagnostic or therapeutic orders which must be dated and signed
- ◆ Documentation of allergies (if the patient has no history of allergies or adverse reactions, this should be noted in a prominent place)
- ◆ Informed consent
- ◆ Documentation of vital signs, assessments, and other findings
- ◆ Any evidence of advance directives
- ◆ Nurses’ notes
- ◆ Laboratory, EKG, and x-rays that are necessary and relevant to the patient’s health status and for the procedure being performed or completed and reports available at the time of surgery. Copies of actual reports or results of each diagnostic study should be in the clinical record. An abnormal laboratory or diagnostic finding that was not addressed appropriately nor resolved prior to surgery is to be reviewed. The patient’s health status, comorbid conditions, and type of surgery should be considered when determining what laboratory or diagnostic studies were relevant for this patient.

Blood pressure, pulse, respiration, and temperature should be taken and recorded prior to surgery.

Abnormal pre-operative results pertinent in interventional pain management include bleeding diathesis and elevated prothrombin time (PT) or international normalized ratio (INR), blood pressure, pulse, respiration, and/or temperature should either be addressed or resolved or the record should explain why they are unresolved. Abnormal findings are defined as those results which fall outside of normal or acceptable limits for the test or physical findings as defined by the laboratory or facility performing the test. In ad-

Table 15. *Medical record (history and physical) documentation guidelines for ambulatory surgical services.*

	HISTORY				EXAMINATION			
	Indications and symptoms	Current medications	Co-morbid conditions/previous surgeries	Social history	Mental status	Specific to proposed procedure and co-morbid conditions	Auscultation of heart and lungs	General health
No anesthesia	√	√	√	√	√	√	Not required	Not required
Intravenous sedation	√	√	√	√	√	√	√	Not required
General	√	√	√	√	√	√	√	√

Table 16. *Medical record (peri-operative) documentation guidelines for ambulatory surgical services.*

<p>Pre-operative medical record requirements</p> <p>Date of admission and discharge</p> <p>Names of referring and attending physicians</p> <p>Pre-operative diagnosis</p> <p>Medical necessity data</p> <p>Pre-operative diagnostic studies or consultation</p> <p>Diagnostic or therapeutic orders</p> <p>Allergies</p> <p>Informed consent</p> <p>Vital signs</p> <p>Advance directives</p> <p>Nurse's notes</p> <p>Laboratory, EKG, and x-rays</p> <p>Anesthesia requirements</p> <p>Pre-anesthesia evaluation</p> <p>Monitoring</p>	<p>Intra- and post-operative documentation requirements</p> <p>Operative note</p> <p>Description of the procedure</p> <p>Post-operative and discharge diagnosis</p> <p>Intra-operative and post-operative complications</p> <p>Vital signs</p> <p>Orders for drugs and biologicals</p> <p>Adverse reactions or complications</p> <p>Practitioner's evaluation prior to discharge</p> <p>Compliance with discharge criteria</p> <p>Condition on discharge</p> <p>Copy of patient instructions</p> <p>Discharge summary</p>
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dition, one can follow the parameters addressed in a policy and procedure manual or by the facility, i.e., the facility or physician with approval of the facility may perform medial branch blocks on a patient with PT of 18, but may not perform a cervical epidural steroid injection unless PT is 16.

6.3 Anesthesia Requirements

Anesthetic requirements include a pre-anesthesia evaluation by an individual qualified to administer anesthesia immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed (1,79-81). In addition, this preanesthesia evaluation should consider data from other assessments and collect information needed to complete selection and planning of anesthesia, safely administer anesthesia, and interpret findings of patient monitoring.

The medical record should also include all the entries reflecting the monitoring of the patient's physiological status during the operative procedure.

6.4 Intra- and Post-Operative Documentation Requirements

Medical records should contain appropriate documentation with the following (79,81):

- ◆ An operative note describing the techniques, findings, and any tissues removed or altered during the procedure.
- ◆ The names of the clinicians involved, the post-op-

erative diagnosis, and the condition of the patient at the end of the procedure.

- ◆ Documentation of any and all complications and evidence of the management of post-operative complications or unusual events.
- ◆ The operative note must be written or dictated immediately following surgery, and must be signed by the surgeon. However, when the operative report is not placed in the medical record immediately after surgery, a progress note should be entered.
- ◆ The record must contain a tissue diagnosis by a pathologist on any tissues removed during surgery excluding those exempted by the governing body.
- ◆ Documentation of the patient's vital signs, level of consciousness, and medications, including IV fluids.
- ◆ Post-operative orders for drugs and biologicals.
- ◆ A report of any adverse reactions to drugs or biologicals to the physician.
- ◆ Documentation of physician's evaluation of the patient to assess for proper anesthesia recovery prior to discharge.
- ◆ Assessment on admission to and discharge from the post anesthesia recovery area.
- ◆ Documentation of discharge from post-anesthesia care area by the responsible independent practitioner or according to discharge criteria.
- ◆ Documentation of compliance with discharge criteria.

- ◆ Condition of the patient on discharge.
- ◆ Documentation of the name of the licensed independent practitioner responsible for the discharge.
- ◆ Discharge diagnosis.
- ◆ A nursing note documenting post-operative abnormalities or complications, vital signs, and general condition of the patient.

6.5 Procedural Documentation

All interventional techniques are considered surgical procedures. Documentation requirements are listed in Table 17.

6.6 Discharge/Disposition

The medical records should document discharge plans (e.g., plans to discharge to home with the care of the family or if there is no family, adequate plans for home care).

- ◆ A description or copy of actual patient instructions and/or education should be included in the patient's medical record.
- ◆ A discharge summary which includes the condition of the patient and any post-operative instructions to the patient should be completed at the time of discharge.

Thus, the ambulatory surgical medical record is an important document. The medical record should be signed and completed by the physician as soon as possible after discharge, however, this time frame should not exceed 10 days (80).

Table 17. *Procedural documentation guidelines for interventional techniques.*

1. History and physical
2. Indications and medical necessity
3. Description of the procedure Consent Monitoring Sedation Positioning Site preparation Fluoroscopy Drugs utilized Needle placement Complications
4. Post operative monitoring
5. Discharge and instructions

7.0 DOCUMENTATION FOR HOSPITAL OUTPATIENT DEPARTMENT

7.1 Informed Consent

This is similar for all settings.

7.2 History and Physical Examination

History and physical the requirements are the same as described for ambulatory surgery centers. A pre-procedure note by the practitioner is usually required the day of the procedure, especially if another provider performed the history and physical examination. The record should always document the physician's examination of the patient performed immediately prior to surgery.

7.3 Monitoring

The degree of monitoring is a function of the patient's medical condition and the type of anesthesia used. A local anesthetic without sedation in an otherwise healthy patient may require nothing more than a blood pressure and a pulse oximeter. A general anesthetic performed on an ill patient might require invasive monitors and additional monitoring.

7.4 Intra-and Post-Operative Documentation Requirements

The documentation requirements are similar to intra- and post-operative documentation requirements provided for ambulatory surgery centers.

7.5 Procedural Documentation

Procedural documentation for interventional techniques is illustrated in Table 17.

8.0 IN-OFFICE DOCUMENTATION

An in-office document is similar to that of the ambulatory surgery center or hospital outpatient department, however many of the physicians misunderstand these requirements and appropriate documentation is not carried out. The OIG report on Medicare Payments for Facet Joint Injection Services (10) showed significant deficiencies in office settings not only with documentation, but also with billing and coding. The error rates were lower in a facility setting compared to an office setting (71% versus 51%). Further, based on speciality error rate in an office setting, IPM-09 scored the best with a 12% error rate, whereas several specialties scored a 100% error rate. Anesthesiology had a 63% error rate, pain medicine (-72) a 56% error rate,

and physical medicine and rehabilitation a 50% error rate.

All the requirements are essentially the same except for an official history and physical and specific requirements in some states with regards to laboratory examinations, etc.

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