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The Role of Evaluation and Management Services in Pain Management

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Evaluation and management services are an integral part of interventional pain management. Health Care Financing Administration "HCFA" and American Medical Association "AMA" promulgate rules and regulations in the evaluation and management arena. Proper understanding and appropriate coding is a crucial part of interventional pain management, as consequences of inappropriate coding and insufficient documentation to support charges billed to Medicare include not only civil monetary penalties, but exclusion from Medicare program and prison terms.

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including the past and present illnesses, examinations, tests, treatments, and outcomes. In essence, proper medical record documentation must provide the information and answer the questions including why?, what?, where?, and when?. Descriptors for the levels of evaluation and management services recognize seven components which include history, physical examination, medical decision making, counseling, coordination or care, nature of the presenting problem, and time spent. Based on the type of history, physical examination, complexity of medical decision making, patient evaluation services are of several types, which include problem focused, expanded problem focused, detailed, comprehensive with moderate complexity, and comprehensive with high complexity. History includes chief complaint; history of present illness; review of systems; and past, family, and/or social history. Similar to the history, physical examination also encompasses four types, which include a problem focused examination, an expanded-problem focused examination, a detailed examination, and a comprehensive examination. This review describes evaluation and management services of new patients, as well as established patients with sample office evaluations.

Keywords: E/M Services, New Patients, Established Patients, History, Physical Examination.

Evaluation of new patients and established patients is an integral part of interventional pain management. Current Procedural Terminology (CPT), 4th Edition, is a systematic listing and coding of procedures and services performed by physicians. Most procedural services are identified with a five-digit code, some however are idenfified by three digits (e.g., hospital services, follow up consults). With the CPT coding and recording system, the procedure or service rendered by the physician is accurately identified in most cases. Evaluation and management codes are incorporated in a separate section encompassing the CPT codes from 99201 to 99499 as shown in Table 1. Apart from the American Medical Association "AMA," which developed CPT over the years, the Health Care Financing Administration "HCFA" also promulgates rules and regulations in evaluation and management coding. In the past, physicians followed a simple format of "SOAP," which was an abbreviation for subjective, objective, assessment, and plan. "SOAP" was later expanded to "SOAPER," to include education and return instructions. However, due to the complicated nature of the documentation guidelines proposed by HCFA, "SOAP" and "SOAPER" no longer meet the criteria in many cases. HCFA and AMA and other specialty societies have been struggling with contentious arguments in favor and against evaluation and management guidelines. The latest guidelines were developed in 1997 and were modified in 1998. However, their implementation has been delayed indefinitely. Consequently, HCFA instructed carriers to use either the 1997 or 1995 version of the guidelines when doing physician audits with the caveat that whichever version is beneficial to the physician should be used (2).

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Importance of Evaluation and Management Services

Consequences of inappropriate coding and insufficient documentation to support charges billed to Medicare include civil monetary penalties, exclusion from Medicare Program and finally, prison terms. As always, well informed physicians make the proper code assignments. However, changes in coding and billing regulations are rapid. Hence, education is essential for physicians, nursing staff, office staff, and the entire staff of interventional pain management to ensure compliance and reduce risk of an audit and possible fraud investigation. Generally, Medicare auditors

Table 1: Common CPT Codes for Evaluation and Management Services in Pain Management

A. Office Outpatients

i. New Patients
- 99201 - Problem Focused
- 99202 – Expanded Problem Focused
- 99203 - Detailed/Low Complexity
- 99204 - Comprehensive/Moderate Complexity
- 99205 - Comprehensive/High Complexity

ii. Established Patients
- 99211 – Brief
- 99212 – Problem Focused
- 99213 – Expanded Problem Focused
- 99214 - Detailed/Moderate Complexity
- 99215 - Comprehensive/High Complexity

iii. Office Consultations (New or Established Patients)
- 99241 - Problem Focused
- 99242 - Expanded Problem Focused
- 99243 - Detailed/Low Complexity
- 99244 - Comprehensive/Moderate Complexity
- 99245 - Comprehensive/High Complexity

B. Hospital Services

i. Initial Inpatient (New or Established Patient)
- 99221 - Detailed/Low Complexity
- 99222 - Comprehensive/Moderate Complexity
- 99223 - Comprehensive/High Complexity

ii. Subsequent Hospital Care
- 99231 - Problem Focused/Low Complexity
- 99232 - Expanded Problem Focused/Moderate Complexity
- 99233 - Detailed/High Complexity

iii. Initial Inpatients (Consultations)
- 99251 – Problem Focused
- 99252 – Expanded Problem Focused
- 99253 – Detailed/Low Complexity
- 99254 – Comprehensive/Moderate Complexity
- 99255 – Comprehensive/High Complexity

iv. Follow-up Inpatient (Consultations)
- 99261 – Problem Focused
- 99262 – Expanded Problem Focused
- 99263 – Detailed/High Complexity

Adapted from Reference 1

focus on patterns of error or errors, but not the occasional honest coding error. However, one should remember that ignorance is not a defense with HCFA.

A recent audit by the Department of Health and Human Service's (HHS) Office of the Inspector General "OIG" revealed that insufficient or lack of documentation was the number one error when medical records were reviewed. Consequently, all physicians, specifically interventional pain physicians (as pain management is a targeted area,) can expect to see increased efforts by Medicare to conduct not only post-payment reviews, but also to identify and target physicians submitting potentially false claims (3).

HCFA reported that, in 1977 alone, it recovered over $1 billion with 1,400 prosecutions and 2,700 Medicare exclusions (3). HCFA also reported that each year over $23 billion is wasted in health care expenditures. By the year 2003, the Health Insurance Portability and Accountability Act "HIPAA" will allocate $190 million in funding to recover overpayments and investigate fraud and abuse of federal health care programs. A dire warning to physicians is that all it takes to incur a million-dollar fine is to be found guilty of a billing violation, affecting 200 patients (3). In addition, it is also estimated that 40% of the money paid to physicians from Medicare Part B is for evaluation and management services. It is reported that, in some states, review of medical record documentation by Medicare, is resulting in an astonishing 75% to 80% insufficient documentation for the level of evaluation and management service billed to the carrier (3). Coupled with this is the finding of OIG, of 23 billion in Medicare overpayments, which represented about 14% of total annual Medicare expenditures. Astonishingly, about half of the identified errors were due to lack of sufficient documentation as to the medical necessity.

Issues of Medical Necessity

Medical necessity requires appropriate ICD-9-CM diagnosis codes with their distinct rules for Volumes I and II to justify services rendered and indicate the severity of the patient's condition. Balanced Budget Act (HR2015, Section 4317), requires all physicians to provide the diagnostic information for all Medicare/Medicaid patients starting from January 1, 1998, failure of which can result in prosecution (3). The International Classification of Diseases, also known as ICD-9-CM is a system used to document complaints, symptoms, conditions, problems, and diagnosis for an encounter or procedure. Physicians should code by listing the ICD-9-CM diagnostic codes shown in the medical record to be chiefly responsible for the services provided, while listing additional codes to describe coexisting conditions. Coding should be to the highest degree of certainty for each encounter. When the medical record

contains the terminology such as "working diagnosis," "rule-out," "questionable," "suspected," and "probable" diagnoses, these should not be listed with ICD-9 codes. However, one silver lining is that chronic conditions treated on an ongoing basis may be reported as many times as the patient receives treatment and care for the condition. In addition, if the proper diagnosis is not established, codes that describe symptoms and signs, as opposed to the diagnosis, are acceptable for reporting purposes until the diagnosis is confirmed by the physician.

In contrast to medical necessity, screening is defined as an examination or diagnostic procedure performed in the absence of signs or symptoms.

While the health care profession is just getting use to ICD-9 and proper documentation, it appears that ICD-10 could be implemented around the latter part of the year 2003 (3).

Wide Arena of Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including the past and present illnesses, examinations, tests, treatments, and outcomes. The medical record facilitates (2, 3):

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

Simply put, proper medical record documentation as a written or dictated note, provides the information with regards to:

- **Why** did the patient present for care?
- **What** was done?
- **Where** the services rendered?
- **When** is the patient to return or what is the plan of action?
- **Will** there be follow-up tests or procedures ordered?

Inaccurate coding and billing will result in various deleterious consequences, as listed in Table 2.

Overview of E/M Services

The descriptors for the levels of evaluation and management services recognize seven components, of which three components are considered key factors in defining the levels of evaluation and management services in interventional pain management (1-3). These components are:

- History
- Physical Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

When counseling or coordination of care are the predominant services provided (more than 50%) by the physician, then time may be considered the key or controlling factor to qualify for a particular level of evaluation and management services.

"Because the level of evaluation and management service is dependent on two or three components, performance and documentation of one component at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of evaluation and management service (2)."

New Patient Evaluations

New patient evaluations are divided into history, examination, medical decision making, and typical time spent face to face with the patient and/or family.

Table 2. Consequences of inaccurate coding and billing

◆ Denied Claims
◆ Suspended Claims
◆ Claims Returned as Unprocessable
◆ Delay in payments until the review is completed
◆ Down coding
◆ Fines
◆ Sanctions
◆ Exclusion
◆ Prison

Table 3: New Patient Evaluation

Type of Visit	Documentation of History				Physical Examination	Complexity of Decision Making
	Chief Complaint (CC)	History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and Social History (PFSH)		
Problem Focused	✓	Brief 1-3 Elements	N/A	N/A	Limited to affected body areas 1-5 elements	Straight Forward
Expanded-Problem Focused	✓	Brief 1-3 Elements	Problem Pertinent Positives & Negatives	N/A	Limited to symptomatic or related systems 6 elements	Straight Forward
Detailed	✓	Extended At least 4 elements or status of 3 chronic or inactive elements	Extended Positive and Pertinent negatives 2-9 systems	Pertinent To problems identified in HPI	Extended examination of symptomatic and related systems 12 elements	Low Complexity
Comprehensive	✓	Extended At least 4 elements or status of 3 chronic or inactive elements	Complete At least 10 systems	Complete At least one specific HPI from 3 of 3 history areas	Complete single system examination All elements	Moderate Complexity
Comprehensive Complex	✓	Extended At least 4 elements or status of 3 chronic or inactive elements	Complete At least 10 systems	Complete At least one specific HPI from 3 of 3 history areas	Complete single system examination All elements	High Complexity

Types of Services: These include new patient office visits or other outpatient or office consultations, hospital inpatient care, hospital inpatient consultations, or emergency department services

Levels of Services: Based on the type of history, physical examination, complexity of medical decision making, and other issues, new patient services are of several types:

- ❖ Problem focused
- ❖ Expanded problem focused
- ❖ Detailed
- ❖ Comprehensive with moderate complexity
- ❖ Comprehensive with high complexity

History:

Each of all four types of evaluations and visits, namely problem focused, expanded problem focused, detailed, and comprehensive includes some or all of the following elements (2):

- ❖ Chief complaint (CC)
- ❖ History of Present Illness (HPI)
- ❖ Review of Systems (ROS)
- ❖ Past, Family, and/or Social History (PFSH)

To qualify for a given type of history, all three elements, which include ROS, PFSH, and type of history must be met in addition to the chief complaint, which should be documented at all levels (Table 3). The required documentation is progressively increased for each type of history, with progression from problem focused to comprehensive complex visit. Nevertheless, the extent of history obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

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 reflected in the medical record.

History of Present Illness: 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 previ-

ous encounter to the present (2). It includes the following elements in general and interventional pain management in particular:

- **Location** – Describing the area of the body
- **Quality** - Sensation or pattern. Satisfied by McGill's pain questionnaire
- **Severity** – Satisfied by pain rating scale, 1-10 or other type of scale
- **Duration** – Symptom duration since the 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 and results with these measures such as physical therapy, surgery, injection therapy, drug therapy, etc
- **Associated signs and symptoms** – Such as numbness, weakness, blurred vision, disturbed sleep pattern, or difficulty with activities of daily living, etc

Brief and extended HPI's are distinguished by the amount of detail needed to accurately characterize the clinical problem(s) (2, 3). For a brief HPI, the medical record should describe one to three elements of the present illness. For an extended HPI, at least four elements of the HPI, or the status of at least three chronic or inactive conditions must be documented. A brief HPI is required for problem focused and expanded problem focused visits. Whereas, extended HPI is required for detailed and both types of comprehensive HPI.

Review of Systems: 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 (2, 3). For purposes of the ROS, the following systems are recognized:

- Constitutional symptoms
- 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 involves the documentation of the patient's positive responses and pertinent negatives for the system related to the problem. For an extended ROS, the requirement is that the patient's positive responses and pertinent negatives, for two to nine systems, be documented. Finally, for a complete review of systems, the inquiry should be made and documentation be carried out for at least ten organ systems. While those systems with positive or pertinent negative responses must be individually documented, a notation indicating the remaining systems are negative is acceptable. In the absence of such a notation, at least ten systems must be individually documented. As shown in Table 3, ROS is not required for problem focused visits. However, for expanded problem focused visits, problem pertinent, ROS is required. In contrast, for detailed visits extended ROS with positive and pertinent negatives, including 2 to 9 systems is required. Finally, for comprehensive visits, complete review of at least 10 systems is required.

Past, Family, and/or Social History: The PFSH consists of:

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

A pertinent PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI and documentation of with at least one specific item from any of the three history areas. For complete PFSH, the documentation requires at least one specific item from each of the three history areas.

No PFSH is required for problem focused and expanded problem focused visits. However, a pertinent PFSH is required for detailed visits and complete PFSH is required for comprehensive visits.

Examination

There are four types of examinations, which encompass all types of new patient evaluations:

- A **problem-focused** examination essentially in-

volves only the affected body area or organ system, OR
includes examination of one to five bullet point elements from a single system examination such as musculoskeletal.

- An **expanded-problem focused** examination involves:
  - A limited examination of the affected body area or organ system, and
  - Any other symptomatic or related body areas or organ systems, OR
    documentation of at least six of the bullet point elements from one of the ten single organ system examinations

- A **detailed** examination is an extended examination of the:
  - Affected body area or areas or organ system(s), and
  - Any other symptomatic or related body areas or other organ system or systems, OR
    documentation of at least twelve bullet elements from one of the ten single system examinations

- A **comprehensive** examination entails one of the following:
  - A general multisystem examination OR
    A complete examination of a single organ system and other symptomatic or related body areas or organ systems

Various types of examinations include general multi-system examination and the single organ system examinations for:

- Cardiovascular
- Ears, nose, mouth, and throat
- Eyes
- Genitourinary – female
- Genitourinary – male
- Hematologic/lymphatic/immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

A general multisystem examination or a single organ system examination may be performed by any physician, regardless of the specialty. The type of examination, whether it is general, multisystem, or single organ system and its content(s) are selected by the examining or consulting physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem or problem(s). In interventional pain management, a general multisystem examination or a single organ system examination of the musculoskeletal or neurological systems will meet the patients needs. Since most of the patients seen in interventional pain management present with musculoskeletal problems, the musculoskeletal single organ system evaluation will fit the needs of a patient with chronic pain. However, if the presenting symptoms are non-musculoskeletal in nature, then either a neurological system or psychiatric system may be utilized. The descriptions herewith for interventional pain management evaluation and management codes for new patients are based on utilizing a musculoskeletal system examination. Some of the ground rules in the evaluation of a chronic pain patient with musculoskeletal problems are as follows (2, 3):

- Performance and documentation of one component at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of service.
- The three key components are history, examination, and complexity of medical decision making.
- The chief complaint, review of systems, and past, family, or social history may be listed as separate elements of history, or they may be included in the description of the history of the present illness.
- The review of systems and the past, family, and social history may be recorded by ancillary staff or on a form completed by the patient. However, the physician must document that the information was reviewed by making a notation supplementing or confirming the information recorded by others. If the history is unobtainable, either from the patient or other source, the record should describe the patient's condition or other circumstance, which precludes obtaining a history.
- "Abnormal" – A notation without elaboration is insufficient. Specific abnormal and relevant findings of the examination of the affected or symptomatic body area or areas or organ system or systems should be documented.
- Abnormal or unexpected findings of the examination of any asymptomatic body area or areas or organ system or organ systems should be described.
- "Negative" or "normal" is sufficient to document normal findings related to unaffected area or areas of asymptomatic organ system (s).
- Documentation for each element must satisfy any numeric requirements.

- Elements with multiple components, but with no specific numeric requirements require documentation of at least one component.
- For musculoskeletal examination, important systems or body areas include **constitutional, musculoskeletal, skin, and neurological/psychiatric areas.**
- For problem focused examination, at least 1-5 elements must be identified from constitutional, musculoskeletal, skin, and neurological/psychiatric areas.
- For expanded problem focused, at least 6 elements must be identified from the same areas as above.
- For detailed examination, at least 12 elements must be identified from the above listed areas.
- For comprehensive evaluation, all the elements from the above listed areas must be included, plus other systems including peripheral vascular system and lymphatic system.

Sample Comprehensive Initial Evaluation

PHYSICIAN - _____

IDENTIFYING INFORMATION:

Name:	Jane Smith
Address:	1344 Any Street Anytown, USA 43035
Telephone:	(888) 777-3333
Date of Birth:	1/1/52
Age (yrs.):	47
S.S. #:	111-22-3333
Date of Evaluation:	6/23/99

HISTORY

Chief Complaint | 1 element |

'Headaches, neck pain, back pain. ''

History of Present Illness

Brief: 1-3 elements for problem focused or expanded problem focused Extended: 4+ elements for detailed and comprehensive Total - 8 elements

Ms. Jane Smith was a 47 year old white female who presented for evaluation and treatment of multiple pain problems. She provided the history. She was a fair historian. She stated that her neck pain associated with headaches and shoulder and upper extremity pain started after the motor vehicle injury on January 29, 1996; whereas low back and lower extremity pain started after motor vehicle injury on August 10, 1998.

Following the motor vehicle injury on January 29, 1996 she was taken to the E.R. where she underwent x-rays. She was a passenger in the car and her husband was driving. She was wearing her seatbelt. Pain started immediately. There was no loss of consciousness. Subsequently she was referred to a neurosurgeon. After initial investigations she underwent physical therapy which did not help her much. She was seen by the neurosurgeon on multiple occasions. She was also tried on various pain medications, however nothing was helping her. Medications provided her with only temporary relief. Subsequently. she was followed by her medical doctor, who referred her to a neurologist.

She underwent further investigations and the neurologist continued to give her pain medications. Again he ordered physical therapy on multiple occasions.

She stated that she was involved in a second motor vehicle injury on 8/10/98 while she was driving when a car pulled in front of her causing the crash. She was wearing seat belts. There was no history of loss of consciousness. She was taken to the E.R. by her husband. At this time, she underwent x-rays of her neck and back, which were shown to be within normal limits. She was provided with pain medication. While initially she was sore all over her body, two days later she started experiencing low back pain, neck pain, headache and arm pain became much worse. After that, she was seen by her medical doctor and was referred to a neurologist. She received pain medication as well as physical therapy without any significant relief or long term relief but she did receive temporary relief. She stated that within a few days, pain started radiating into both lower extremities.

Symptomatology:
1. Severe low back pain with radiation into both lower extremities, mostly on the right side, occasionally on the left side since August 10, 1998.

2. Pain in the neck associated with headaches and radiation into both shoulders as well as right upper extremity all the way into the fingers mainly associated with occasional radiation into the right upper extremity since January 29, 1996.

Pain Ratio: With regards to low back she described that:
She experiences both back and leg pain, which are equal.

With regards to neck pain she stated that:
She experiences both neck and arm pain, however, the neck pain is worse than the arm pain.

Pain description: She described her pain on McGill's Pain Questionnaire utilizing the various descriptors with severity as well as character as follows:

She experiences unbearable shooting, severe sharp, stabbing, aching, moderate throbbing, and mild cramping types of pain.

Time spent in pain: She stated that she spends almost 2/3rds of a day in pain.

Associated symptoms with pain: She stated that she experiences associated symptoms with pain such as numbness, pins and needles, and weakness.

Pain intensity: She described her pain today as 6-8, her least pain as 4-5, her worst pain as 9, and her overall average pain as 7-8.

She also described that she has only two good days with mild or discomforting pain in a typical week. In addition to this, she also stated that she generally experienced five bad days per week where the pain is horrible or excruciating.

Factors changing the pain: She stated that overhead activity, sitting, lifting, cold weather, damp weather factors make her pain significantly worse; where as sexual activity, bending forward, bending backward, bending to same side, bending to opposite side, driving, coughing/sneezing factors make her pain somewhat worse. In contrast, she also described that walking, lying down/resting, makes her pain somewhat better. She described that she experiences no changes in her pain pattern with standing.

Activities of daily living: She stated that generally she is capable of walking, sitting, standing, climbing stairs, dressing herself, and driving car unassisted.

Effect of pain on activities: She stated that since the onset of pain personal activities, household activities, family activities, recreation & hobbies, sexual relations, physical exercise, watching TV have decreased quite a bit.

Pain diagram: On the pain diagram, she showed her pain to be present in the low back with radiation into both lower extremities which she showed as internal and external and 4 on a scale of 0-5. She also showed pain to be present in the neck with radiation into head as well as both shoulder blades and right upper extremity.

Sleep pattern:
She stated that her sleep pattern has changed after the onset of the pain. She stated that she has a problem falling asleep at least 3-4 nights a week. In addition, she stated that she wakes up 1-2 times each night, which on average happens 2-3 nights a week. She stated that she generally tries to sleep 6-7 hours each night. However, she actually sleeps only 3-4 hours. She stated that, after sleeping, when she wakes up in the morning, she is in pain and tired. She stated that she does not sleep during the daytime.

Past, Family, Social History

Pertinent: to problems identified for comprehensive Complete 3 or 3 areas

Past history:
She denied any type of motor vehicle injuries or any other type of trauma to her spine. She also denied any other type of injury. She denied any pain problems related to spine or joints in the past. She also denied any pre-existing disability.

There was no history of chronic medical problems including hypertension, heart disease.

Evaluation and treatment history for pain:
She was seen in the E.R. on two occasions with both the accidents. She was also seen by her medical doctor on a regular basis. She was seen by a neurologist and neurosurgeon. She underwent multiple investigations.

In the past, she stated that she underwent regular X-rays of neck and back, myelogram, and MRI scans.

She never underwent any chiropractic treatments, however she underwent physical therapy, extensively since 1996. She stated that she underwent physical therapy at least once in three months lasting for six weeks or so each time with 18-20 visits. The physical therapy provided only mild and temporary relief. She never obtained any long-term relief. She never underwent any psychotherapy, epidurals, nerve blocks or other modalities of treatments.

She stated that she is taking the following medications for management of her present problems:

Xanax .25 mg. h.s.
Talwin NX bid

She stated that these medications provide some relief. She stated that she experienced no side effects with these medications. In addition to the above, she stated that she tried various other medications, which included nonsteroidal anti-inflammatory agents, various types of pain medications, and muscle relaxants.

Family history:
There was no history of neck pain, low back pain, arthritis, migraine, lupus, multiple sclerosis or fibromyalgia in her family.

Social history:
Environmental history: With regards to the education she stated that she completed 12th grade. She stated that she has been married. She also stated that she lives with her husband. With regards to previous marriages, she stated that she was never married before. She has 2 boys and 1 girl of ages 18, 16 and 14 years. She stated that her marriage is completely satisfactory. She stated that her pain problems have changed her relationship with her husband and family members.

Occupational History: She stated that, her present occupation is operator at Bell South. She held this job for 29 years and working 40 hours per week. In addition to this, she described that her work involves sitting for 8 hours per day. With regards to vibrations, she stated that her work does not involve any vibration. She also stated that she has missed work because of the current problems.

Habits:
She does not smoke. She does not drink alcohol and she never had a problem with alcohol. She drinks tea daily. She does not use any street drugs.

Hobbies:
Her hobby is gardening. However, she also stated that she is unable to participate in her hobbies because of pain.

REVIEW OF SYSTEMS

Problem pertinent: 1 system for expanded problem focused
Extended: 2-9 systems for detailed
Complete: 10+ systems for comprehensive

Constitutional:
She stated that there was no history of recent weight loss, weight gain, recurrent fever, fatigue or general weakness, etc.

Skin:
There was no history of dry skin, recurrent rashes, psoriasis, difficulty with healing, or acne, etc.

Lymphatic/Hematological:
There was no history of swollen glands anemia, easy bruising, excessive bleeding, history of blood transfusions, HIV exposure, HIV positive status, or history of AIDS.

Head and Face:
There was history of headaches from neck, but there was no history of facial pain.

Eyes:
There was no history of major abnormalities.

Ear/Nose/Mouth:
No gross abnormalities were reported.

Chest/Breasts:
No gross abnormalities were reported.

Respiratory:
There was no history of major abnormalities with pulmonary system.

Cardiac/ Peripheral Vascular:
Cardiac: There was no history of heart trouble, swelling of feet, rheumatic fever, high blood pressure, chest pain, heart attack, bypass surgery, leaking valves, heart murmur, heart failure, mitral valve prolapse, or valvular surgery.

Peripheral / Vascular: There was no history of vascular surgery, varicose veins, poor circulation or blood clots in arms or legs.

Hepatic-Biliary/ Gastro-intestinal/ Abdominal:
No gross abnormalities were reported.

Urinary:
There were no abnormalities reported.

Genital/Reproductive:
No gross abnormalities were reported.

Endocrine:
She reported thyroid trouble, which was underactive.

Musculoskeletal:
She presented with history of neck pain, low back pain. However, she reported that there was no history of generalized arthritis, joint pain, stiff joints, rheumatoid arthritis, gout, heel spurs.

Neurological / psychiatric:
Neurological: Neurological history revealed no evidence of fainting, stroke, weakness, neuropathy, black out spells, seizures, gait disturbances, dizzy spells, coordination difficulties, or tremors.
Psychiatric: There was no history of any abnormalities reported with concentration, problems with thinking or thought process, problems with short term or long term memory. There was also no history of obvious depression, anxiety, shakiness or agitation.

Allergies / Immunologic:
Drug allergies: Lortab and Elavil.
Food allergies: None
Environmental allergies: None
Immunologic: There was no history of any immunologic disorders.

Previous Surgeries and Hospitalizations:
Hysterectomy, cholecystectomy, appendectomy.

Medications:
Xanax .25 mg. h.s.
Talwin NX bid
Synthroid 0.175 mg. q day
Motrin 200 mg prn

Psychosocial Evaluation

(not a requirement)

Proper evaluation of chronic pain often requires an appropriate psychological evaluation. Even though most clinicians who have experience in treating chronic pain have developed skills to assess emotional or psychological parameters complicating pain problems, or psychological variables affecting the pain, it is well known that they are often unable to identify which of the variables are the most operative, or which psychological diagnoses are present. In fact, Waddell, et al showed that so called psychological impressions by physicians were hopelessly inaccurate when compared to appropriate psychological evaluation. Hence, it is assumed by the clinicians at Pain Management center that besides producing physical limitations, chronic pain almost always causes some emotional disturbances and it is essential to explore the emotional aspects of the patient and the everyday effects of pain on the patient. Her psychological evaluation was conducted by reviewing various answers she provided on comprehensive pain management questionnaire and biography, along with a personal interview. In addition to the above, she also underwent Millon Clinical Multiaxial Inventory II (MCMI-II).

Validity: MCMI-II has been shown be valid.

Developmental history: Ms. Smith was raised by her mother and father. She stated she comes from a family of 7. She described her mother's personality and attitude towards her, past and present as, ''She is dedicated to all her children.''. She described her childhood and home life while growing up as neither happy nor unhappy. Ms. Smith reported that she has not experienced any unusual experiences in the childhood or as teenager.

Gross psychological pattern: In completing the questionnaire and interview, she provided the history that she has not experienced any significant problems with flashbacks/recollections, hallucinations/unusual experiences, dizziness/fainting spells, physical violence, rape/sexual abuse, arrests/jail sentences. However, she stated that she experienced concentration/memory.

On evaluation by MCMI-II, her gross psychological pattern reveals that she is suffering with mild psychological disturbance.

Personality: MCMI-II evaluation revealed the following personality configuration:

1. Obsessive/Compulsive Personality Trait
2. Dependent Personality Disorder

The major personality features described here reflect long term or chronic traits that are likely to have persisted for several years, generally from birth, and have been present prior to the present assessment.

Stress and Anxiety: Patients with chronic pain are often tense, nervous, anxious, irritable, and angry. In addition, these feelings have significant effect on their family and friends, often producing marital strain secondary to tension, anxiety, and apprehension, either justified or not.

For stress and anxiety evaluation, pain management questionnaire presented five questions, which include inquires about excessive worry and anxiety, difficulty to control worries, features associated with anxieties such as restlessness, fatigue, difficulty with concentration, irritability, and sleep disturbances.

She stated that she has been tense, nervous, and anxious. Based on her answers, she suffers with substantial evidence of stress and anxiety leading to the diagnosis evidence of Generalized Anxiety Disorder.

She was also evaluated utilizing MCMI-II evaluation for presence or absence of generalized anxiety disorder. On this evaluation, her score was 52 without diagnostic impression of Generalized Anxiety Disorder.

Depression: Chronic pain patients are often reluctant to use words such as depression, but they are generally free to discuss the frustration, anger, irritability, guilt, and fear. The literature has documented overwhelmingly that chronic pain patients suffer with insomnia, fatigue, lack of interest, poor concentration, and feelings of hopelessness which are features of depression, even if the patient does not admit to it directly.

This psychosocial evaluation, specifically concentrating on depression, explores patients psychological status by questioning on 15 items, which include scope of depression, feelings of irritability and restlessness, lack of interest in activities, weight gain or weight loss, loss of appetite, sleep pattern, fatigue, lack of energy, guilt, inability to concentrate, thought(s) of suicide, or actual attempt(s) at suicide.

She indicated that she feels mildly depressed. She reported that her family and friends also think she is depressed. She described herself as irritable or restless and agitated. She reported a loss of interest in all, or almost all activities, most of the time. She also reported having trouble getting to sleep or awakening frequently and having difficulty falling back to sleep. She reported that she feels sluggish and slow and can't seem to get going, and this occurs nearly every day. She experienced fatigue or loss of energy nearly every day as well. She feels her ability to think, concentrate and make decisions are diminished.

Of the various aspects of depression evaluated based on DSM-IV criteria, she presented with evidence indicating a state of Major Depression.

She was also evaluated for evidence of Dysthymia, and for Major Depression on MCMI-II. On this evaluation, her scores were Dysthymia 35, and Major Depression 54.

Somatoform implications: Somatization disorders are sometimes seen in conjunction with chronic pain very rarely, chronic pain may be the result of somatization disorder. The essential future of somatization disorder is a pattern of recurring, multiple, clinically significant somatic complaints. A somatic complaint is considered to be clinically significant if it results in medical treatment or causes significant impairment in social, occupational or other important areas of functioning.

On MCMI-II evaluation, her score for Somatization Disorder was 77 with diagnostic impression of Somatization Disorder.

Previous Psychological/Psychiatric Management:
She stated that she never had previous psychological/psychiatric treatment or evaluation.

She stated that there is no family history of emotional problems, or alcoholism/drug abuse.

Physical Examination

Problem Focused: 1-5 elements Expanded problem focused: 6 elements Detailed: 12 elements Comprehensive: all elements

Constitutional: 2 elementsor bullets
Vital Signs: Her height was 5 ft. 2 inches. Her weight was 120 lbs. Her sitting blood pressure was 130/90 mm/Hg. Her pulse rate was 78 per minute and regular. Her respiratory rate was 16 per minute.

General appearance: She was well developed, well nourished, her build was normal, she was independent, there were no physical disabilities noted, and she was well groomed.

Skin: 1 bullet or element
Examination of the skin showed abdominal scars. There was no rashes, lesions, ulcers, or café-au-lait spots either in the head, truck, upper extremities, or lower extremities.

Hematologic/Lymphatic: 1 element or bullet
Examination was grossly within normal limits with no evidence of anemia, cyanosis, or enlarged lymph nodes either in the neck, groin, axilla, or any other regions.

Eyes: There were no gross abnormalities noted.

Ears, Nose, Mouth, and Throat: Grossly within normal limits.

Chest: Grossly within normal limits.

Respiratory: Grossly within normal limits with normal breath sounds.

Cardiovascular: 1 element or bullet
Heart: Grossly within normal limits with a normal PMI with no evidence of rhythm or rate abnormalities or murmurs. Her carotid pulses were grossly within normal limits.

Peripheral: Examination of the peripheral vascular system showed no evidence of swelling or varicosities, temperature abnormalities, edema, or tenderness. Pulses were grossly within normal limits.

Gastrointestinal (Abdomen): Grossly within normal limits.
Genitourinary: Genitourinary examination was deferred.

Psychiatric: 2 elements or bullets
Psychiatric evaluation showed orientation to time, place, and person with normal mood and effect with no history of lack of memory, concentration, attention span, language difficulties or knowledge.

Musculoskeletal/Neurological Examination: 8 elements or bullets

Dominance: She was right handed.

Posture: Her posture showed normal cervical lordosis, normal lumbar lordosis, mild kyphosis, and mild scoliosis.

Gait: Her gait pattern showed that she was able to walk in a straight line, as well as on her heels, and toes without any problems.

Coordination: Her coordination with examination of the fingers/nose, heel/knee/shin, rapid alternating movements in upper extremities, and rapid alternating movements in lower extremities was grossly within normal limits.

Cranial nerves: Grossly within normal limits.

Head/Face/Neck:
Head: Examination of her head revealed no evidence of scars, lesions, masses, crepitation, asymmetry defects, tenderness, or effusions.

Face: Examination of her face showed no evidence of scars, lesions, masses, crepitation, asymmetry, defects, tenderness, effusions, sinus tenderness, or enlarged salivary glands.

Neck: Examination of her neck showed no evidence of scars, lesions, masses, crepitation, asymmetry defects, tenderness, effusions, enlarged salivary glands, thyromegaly, tracheal deviation, or jugular distention.

Cervical Spine:

Inspection - On inspection her cervical lordosis was normal. There was no evidence of scars, masses, lesions, effusions, asymmetry, defects, contractures, laxity or fasciculations.

Palpation: There was no evidence of masses, lesions, effusions, defects, contractures, crepitus, dislocation, subluxation, laxity or fasciculations.

She had significant mid-line as well as spinous process tenderness. She had no evidence of superficial or nonanatomic tenderness. She had moderate bilateral paravertebral tenderness extending throughout the cervical spine with moderate spasm. There was significant suboccipital as well as periauricular tenderness. She also had moderate upper trapezius tenderness, however with no evidence of trigger points. There was no tenderness noted in the shoulders, AC joints, arms, elbows, forearms, wrists or fingers.

Range of Motion - Cervical range of motion by manual examination showed 10% approximately reduction with flexion, extension, lateral rotation and lateral flexion with elicitation of mild pain.

Range of motion of the both shoulders was normal with no evidence of impingement. Range of motion of all other joints was grossly within normal limits.

Motor Examination - Motor examination was grossly within normal limits, with normal tone and no wasting. There were no abnormal movements noted.

Wasting - There was no wasting noted.

Grip Strength - Her Grip Strength showed some mild decrease on right side and moderate decrease on left.

Sensory evaluation - There was no sensory dysfunction noted in either upper extremity.

Reflexes - Her deep tendon reflex evaluation showed the following:

		Right	Left
1.	Biceps	1	1
2.	Triceps	1	1
3.	Brachioradialis	1	1

Other neurological tests:

	Right	Left
Tinel's Test	Negative	Negative
Adson's Test	Negative	Negative
Compression Test	Negative	Negative
Spurling's Sign	Negative	Negative

Non-physiological signs - Non-physiological signs for cervical spine, which were derived from Waddell's non-physiological signs for low back pain were utilized with four categories with the following responses.

i. Non-specific tenderness (Superficial/non-anatomic)	Negative
ii. Presence of distraction	Negative
iii. Regional (motor/sensory)	Negative
iv. Simulation	Negative

Thoracic Spine:

Thoracic spine examination was grossly within normal limits with no evidence of scars, lesions, masses, effusion, asymmetry, defects, crepitus, contractures, or fasciculations. There was no significant tenderness noted.

Lumbar Spine:

Inspection - Inspection of her lumbar spine showed normal lumbar lordosis. There was no evidence of scars. Her lumbar spine evaluation showed mild scoliosis and mild kyphosis. Her both lower extremities appeared to be equal in length. There was no evidence of scars, lesions, masses, effusion, defects, crepitus, contractures or fasciculations.

Palpation – She had moderate mid-line as well as spinous process tenderness extending from L3-S1. However there was no superficial or nonanatomic tenderness. She had significant bilateral paravertebral tenderness, which was severe on the right side and moderate on the left side with mild spasm on the left side and moderate spasm on the right side. She had some tenderness in the sciatic notch, which was worse on the right side than on the left side. She also had

tenderness in the SI joint on the right side, which was only mild to moderate on the left side.

Range of motion - The range of motion evaluation included the evaluation of the lumbar spine, both hips, knees, and ankles. Range of motion of her lumbar spine by manual examination showed about 10% reduction with flexion with moderate pain, and approximately 40% reduction with extension with severe pain. She also experienced severe pain with deflexion. Lateral rotation and lateral flexion were decreased about 20-30% with mild pain.

Range of motion of the both hips normal with negative Patrick-Fabere's Test.

Examination of all other joints was grossly within normal limits.

Motor Examination: Grossly within normal limits with no evidence of wasting. Muscle tone was normal with no abnormal movements.

There were no focal neurological deficits noted.

Sensory -Sensory examination was within normal limits.

Reflexes - Her deep tendon reflex evaluation showed the following:

	RIGHT	LEFT
Quadriceps Femoralis	1	1
Achilles	1	1

Superficial reflexes were shown to be within normal limits.

Straight leg raising - Straight leg raising results were as follows:

	RIGHT	LEFT
Straight Leg Raising		
Sitting	90°	90°
Supine	70°	70°
Back pain	Positive	Positive
Sciatic Tension Signs	Negative	Negative

Non-physiological signs – Non-physiological signs were described by Waddell, et al. Originally these included five non-physiological signs for lumbar spine, which included non-specific tenderness, simulation, distraction, regional disturbances, and over-reaction. However, over-reaction was removed from the non-physiological signs later on. Hence, the remaining four categories were evaluated:

1.	Non-specific tenderness (Superficial/non-anatomic)	Negative
2.	Simulation (Axial loading/rotation)	Negative

3.	Distraction (Range of motion/SLR)	Negative
4.	Regional Disturbances (Motor/sensory)	Negative

Medical Decision Making

Treatment Goals:
In this questionnaire, as well as personal interview, we offered the patient the option to describe goals of the treatment in order to importance with a level of importance being 1 to 10 with common goals such as return to work, be active and functional, play with kids and grandkids, have sexual relations, and participate in sports. On this evaluation, she described her goals with a level of importance marked as follows:

1. Be more active and functional
2. Play with kids and grandkids

Review of Investigations:

10/1/97 - Cervical spine - Degenerative disc changes at C4-5 and C5-6 as described above.

10/1/97 - MRI of the cervical spine - Cervical disc protrusion at C5-C6 on the right. Grade I DJD at C5-C6 with slight marginal anterior osteophytosis. The patient is claustrophobic and did have some difficulty with the exam, but we worked with her and was patient and we got through this.

12/10/98 - Lumbar spine - No acute bony pathology.

12/10/98 - MRI of the lumbar spine - Negative MRI for central, subarticular or lateral recess lumbar spinal stenosis.

Review of Records: Multiple records from ER, family MD, neurologist, and neurosurgeon were reviewed.

Impression:

Physical Diagnoses:

1. Severe low back pain with radiation into both lower extremities mainly on the right than the left secondary to:
   a. Lumbar facet joint arthropathy
   b. Sacroiliitis

2. Severe neck pain associated with headaches and radiation into both shoulder blades and right upper extremity secondary to:
   a. Cervical facet joint arthropathy
   b. Cervical disc displacement

3. Hypothyroidism

Psychological Diagnoses:

1. **Axis I - Clinical Syndrome**

   a. Somatization Disorder
   b. No evidence of generalized anxiety disorder
   c. No evidence of dysthymia
   d. No evidence of major depression

2. **Axis II - Personality Disorder/Trait**

   a. Obsessive/Compulsive Personality Trait
   b. Dependent Personality Disorder

Plan

At this time, I explained to her my impressions about her problems and various modalities of treatments available. She continues to work and she has been suffering with substantial amounts of pain, so she wants something to be done so she can get back to her normal lifestyle. At present time she states that the only thing she can do is just work and then she has to go and lie down on the bed without any significant social or family activities. Hence, she is extremely interested in increasing her physical and functional status.

At this time, we discussed about comprehensive modality of treatment with pain management including physical intervention with functional rehabilitation approach as well as psychological intervention with behavior modification, however she stated that she had enough physical therapy and she is sick of it. She does not want to undergo any further physical therapy. In addition to this, she did not feel like she needed any psychological intervention at all. At this time, however she agreed to be started on Serzone which will start with a starter pack and see how she responded to this. She stated that her major problem is the physical problem, which I tend to agree. She wanted to undergo physical treatment for the problems with injection therapy. At this time, I also discussed about injection therapy. We will proceed with bilateral lumbar facet joint nerve blocks and see how she responded to this. We will use the first two as diagnostic blocks. If she did well with the first blocks then there is no necessity for further treatment. However if she failed to respond, we will consider SI joint injections or even caudal epidural with local anesthetic or selective epidural with local anesthetic. She understood and agreed with this. With regards to the cervical spine we will proceed with bilateral cervical facet joint nerve blocks and see how she responded to this. If she failed to respond initially then we will consider cervical selective epidural with local anesthetic.

Overall, if she responded well to the initial injection therapy, there is no necessity for further modalities of treatment. If she failed to respond to injection therapy or if she responded only on a short-term basis then we will consider other modalities including radiofrequency thermoneurolysis, epidural injections with steroids, etc. She understood and agreed with this.

Course of Treatment

Her initial course of treatment will probably last for approximately 9-12 weeks depending on her progress with probable maintenance therapy to follow.

Prognosis

Her prognosis at this time appears to be good.

Discussion

I explained my impressions about the problems and the importance of developing realistic goals of treatment. At this time, we also discussed about various issues involved between acute and chronic pain and the differences and contributing factors. I explained that chronic pain is a complex phenomenon. Hence, it requires a multimodality approach. It was also explained that pain relief is desirable but not always an achievable goal. At this time, I explained to her that our major goals of treatment are:

1. To achieve maximum functional capacity
2. To eliminate the pain if at all possible, however, if not possible, to attempt to decrease the pain level over a period of time, to that a near normal lifestyle can be achieved.
3. Modify pain behavior significantly with positive attitude and other techniques.
4. Avoid pain generating activities with modification of functional status
5. Avoid dependency inducing drugs as much as possible except for under controlled circumstances.

Once again, it was emphasized that chronic pain is an extremely difficult problem and high motivation is required which usually better in combination with physical and psychological modalities. At this time, pros and cons of each modality were discussed. Following this, potential complications and side effects of various modalities and techniques were also discussed specifically with regards to the injection therapy. These complications included hematoma formation with black and blue marks, blood clot formation, infection which is extremely rare, possible reaction(s) to local anesthetic(s), Steroids, Sarapin, contrast, hypertonic saline, phenol, etc along with weakness and numbness which is mostly temporary, however, it could be longer lasting in some cases, inability to relieve the pain, and also rare possibility of increasing the pain.

Discharge/Disposition

Following the above discussions, understanding all associated complications and benefits, it was decided that we will go ahead and discharge her.

She was discharged in satisfactory condition to return in two weeks for further follow-up at which time we will proceed with neural blockade. She was also provided with a prescription for Talwin NX po tid for 45 tablets with no refills. She was also given a Serzone starter pack.

Summary of Sample Evaluation

	Total	Criteria Met
Chief Complaint	**1**	**1**
HPI	**8**	**8**
PFSH	**3**	**3**
ROS	**14**	**14**
Physical Examination	**12+ (Elements)**	**12+**

E/M - Code Level - Comprehensive with moderate complexity

Table 4: Established Patient Evaluation

Type of Visit	Documentation of History				Physical Examination	Complexity of Decision Making
	Chief Complaint	History of Present Illness	Review of Systems (ROS) *	Past, Family, and Social History (PFSH) *		
Brief	✓	Minimal	N/A	N/A	N/A	Minimal
Problem Focused	✓	Brief 1-3 elements	N/A	N/A	1-5 elements	Straight Forward
Expanded Problem Focused	✓	Brief 1-3 elements	Problem Pertinent Positive and negatives for related system	NA	At least 6 elements	Low Complexity
Detailed	✓	Extended At least 4 elements or status of 3 inactive or chronic conditions	Extensive Directly related and other systems Total of 9	Pertinent At least one specific item from one of 3 areas of history	At least 12 elements	Moderate Complexity
Comprehensive	✓	Extended At least 4 elements or status of 3 inactive or chronic conditions	Complete At least 10 organ systems	Complete At least 2 specific items from 3 history areas	All elements	High Complexity

Adapted from references 1-3

* The review and update of ROS and PFSH may be documented by:
Describing any new information or noting there has been no change in the information; and noting the date and location of earlier ROS and/or PFSH

Established Patient Evaluations

The rules for established patients are similar to the new patients in any of the settings with some variations as shown in Table 4. Once again, evaluation of an established patient is also based on single organ system evaluation of the musculoskeletal system.

Sample Established Patient Evaluation

Name: Jane Smith

Date of Birth: 1/1/52
Age (yrs.): 47
S.S. #: 111-22-3333

Date: 9/20/99

Chief Complaint: "I'm hurting again."

History of Present Illness:

> Brief: 1-3 elements for problem focused and expanded problem focused
> Extended: At least 4 elements or status of chronic conditions for detailed and comprehensive

Ms. Jane Smith returns for a follow up. At this time she states that she is slowly starting to have problems again. She

did extremely well following the injection therapy on two occasions with diagnostic facet joint nerve blocks, both for cervical region as well as lumbar region. Following the first injection therapy she obtained 80% relief lasting for three weeks and following the second injection therapy she obtained 60% relief lasting for six weeks. At this time she states that her pain has been returning and her functional status is starting to deteriorate. Hence she wants to undergo further treatment and she how she does with this.

Symptomatology:

1. Pain in the neck associated with headaches and radiation into both shoulders and in upper extremities since 1-29-96.

2. Low back pain with radiation into both lower extremities, worse on the right then left since 8-10-98.

Quality of Pain: Throbbing and cramping. However she stated that she has not experienced any severe shooting, stabbing type of pain.

Pain Rating: She stated that her average pain rating has been around two to three. Today it is four. She has not been experiencing any numbness or weakness.

Effectiveness of Treatment: She stated that she experienced almost approximately 80% relief following the diagnostic blocks lasting for five weeks.

Past Family and Social History: This was reviewed on 6/23/99. There have been no interval changes.

Review of Systems: All of the systems were reviewed on 6/23/99 and there have been no interval changes.

Allergies / Immunologic:
Drug allergies: Lortab and Elavil.
Food allergies: None
Environmental allergies: None
Immunologic: There was no history of any immunologic disorders.

Medications:

Xanax .25 mg. h.s.
Talwin NX bid
Synthroid 0.175 mg. q day
Motrin 200 mg prn

Physical Examination:

Constitutional:

Height:	5'2"
Weight:	118 pounds
Blood pressure:	130/86 in sitting position
Pulse rate:	73 per minute and regular
Respiratory rate:	14 per minute

General appearance: She was a well developed, well nournished, normally built independent with no physical disabilities. She was well groomed.

Musculoskeletal/Neurological:

Dominance: She was right handed.

Posture: Her posture showed normal cervical lordosis, normal lumbar lordosis, mild kyphosis, and mild scoliosis.

Gait: Her gait pattern evaluation showed that she was able to walk in a straight line, as well as on her heels, and toes without any problems.

Coordination: Her coordination with examination of the fingers/nose, heel/knee/shin, rapid alternating movements in upper extremities, and rapid alternating movements in lower extremities was grossly within normal limits.

Reflexes/Nerve Stretch:

Reflexes: Her deep tendon reflex evaluation showed the following:

	Right	Left
1. Biceps	1	1
2. Triceps	1	1
3. Brachioradialis	1	1
4. Quadriceps Femoralis	1	1
5. Achilles	1	1

Straight leg raising: Straight leg raising results were as follows:

	Right	Left
Straight Leg Raising	80°	80°
Sciatic Tension Signs	Negative	Negative

Sensory: Sensory examination was within normal limits.

Inspection percussion/palpation: There was no evidence of scars, lesions, masses, crepitation, asymmetry defects, or effusions, however she had tenderness with mild spasm in both cervical as well as lumbar spine.

Range of Motion:
Range of motion of the cervical and lumbar spine was somewhat reduced, however much improved from her previous evaluation.

Muscle Strength-Tone: Examination of upper and lower extremities show normal muscle strength. Her tone was normal, there was no wasting noted.

Review of Investigations: Review of investigations was performed on 6/23/99 with no further investigations.

Review of records: This was performed on 6/23/99. There have been no interval records.

Impression:

1. Lumbar facet joint arthropathy
2. Cervical facet joint arthropathy
3. Cervical disc displacement
4. Hypothyroidism

Discussion/Plan:

At this time we discussed about various aspects of her pain management since she had done extremely well with the diagnostic blocks confirming the diagnosis of facet joint immediate pain in both cervical and lumbar spine it was decided that we will schedule her for radiofrequency thermoneurolysis of cervical and lumbar spine, however at different sessions. She understood and agreed with this. At this time I also explained to her all associated complications and benefits with this.

Discharge/Disposition:

She was discharged in satisfactory condition to return in two weeks for the follow up. I will see her in two weeks.

Summary of Evaluation:

	Total	Criteria Met
Chief Complaint	1	1
HPI	8	8
PFSH	3	3
ROS	14	14
Physical Examination	12+ (Elements)	12+

E/M - Code Level - Comprehensive with moderate complexity

References

1. Current procedural terminology (CPT) 1999; American Medical Association, Chicago, IL.
2. Evaluation and management services; Anesthesia Answer Book 1999; Rockville, MD; pp 13501-13594.
3. The E/M Chart Audit Answer Book 1999; United Communications Group. Rockville, MD pp 1-337.