



# ACOEM Proposed Alternative Documentation Criteria for Evaluation and Management Encounters

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## Overview

Medical care should be focused on more than symptom reduction – ideally, medical encounters should support the restoration of normal life activities, including participation in school, work, family and society. Attending to *function* as a vital sign will increase the value of medical care in every clinical setting in which impairment or disability is an issue, or potential issue, including urgent care, primary care, specialty care, and disability-related encounters. The documentation that is presently required by the Evaluation and Management (E/M) codes to support requests for reimbursement does not have an optimal functional focus. Specifically, the current E/M criteria call for documenting a multitude of historical and examination elements that do not include the factors shown by research to prevent excessive and often harmful medical care, prolonged disability and other poor outcomes. Because the current coding system does not reimburse providers for documentation of such critically important data elements, there is often insufficient attention to these issues in encounters, with resultant preventable problem outcomes. For this reason, the ACOEM Council on Occupational and Environmental Medicine Practice has developed a proposed functionally oriented approach for documenting E/M encounters. This approach been designed to fit into the current coding paradigm and levels of care, by making minor but important substitutions in specific elements of history, physical examination and medical decision-making, consistent with research evidence for better clinical outcomes, including promoting optimal participation in social roles.

**History.** The clinical history in the function-oriented model should document impact of the condition on functioning in multiple life domains, aggravating activities, risk factors for poor recovery, support systems and any important cultural implications. These elements can be captured with modest variations from the current data elements of a history that captures CMS-required criteria. ACOEM proposes modifying the scoring criteria for the level of history in comparison to CMS criteria by revising the review of systems to capture physical/emotional/mental symptoms most relevant to risk for poor outcomes while also asking about important social systems.

**Examination.** The current CMS comprehensive general physical exam criteria used most commonly requires documenting examination of two bullets from each of nine unrelated organ systems. The resulting documentation rarely provides useful clinical information when the principal goal of medical care is the restoration of function. ACOEM has developed a functionally oriented musculoskeletal examination template that is similar to those used in the 1997 specialty-specific exams. The ACOEM functional examination template follows a format and bulleted coding scheme that promotes a careful examination of both the affected area and the adjacent areas, and comparison with the unaffected side when applicable. This model approach can be used to develop similar examination templates for any clinical problems that involve functional impairment. Additionally, the documentation required by the examination template produces an easily auditable foundation for reimbursement.

**Medical Decision Making.** The proposed new criteria shift the emphasis in the current CMS criteria on medical procedure and disease severity risk, toward risk for poor functional outcomes. These may include risk for unnecessary, harmful medical care and risk for preventable disability. Adopting reimbursement criteria that incentivize providers to identify and mitigate such risks for suboptimal function will benefit all patients, from the young to the very old. The criteria that ACOEM proposes for medical decision-making are very similar to the current CMS criteria, but with a significantly greater emphasis on functional recovery. A multitude of social systems – including Social Security, federal and state workers' compensation, school services for children with special needs, private sector disability insurance, personal injury litigation, and many others – must on a daily basis deal with issues of functional recovery. The need for our medical system to promote efficient returns to function following injury or disease could not be more pressing. In the workplace, risk of chronic work disability is recognized as an equivalent risk to loss of life or limb, based on research showing significantly increased morbidity and mortality for working age adults who are not working. The proposed criteria also describe management strategies appropriate for different levels of risk for preventable disability.

## Symptom-Oriented Model

Symptoms → Diagnose and Treat

What hurts? Where does it hurt? How long has it hurt?  
Review of multiple body systems.

Married? Smoker? Sex life?

Comprehensive head to toe physical; include ‘bullets’  
from unrelated parts of the body

Risk based on danger of condition, diagnostic and  
treatment procedures

Review of past records, diagnostic test results,  
consultation reports

Medical decision making is based on level of risk,  
severity of the clinical problem and amount of data  
reviewed

Plan is focused on diagnostic tests, medication and  
referrals to try to reduce symptoms

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## Function-Oriented Model

Function → Assess and Promote

How has the condition impacted you?

Occupational activities? Job satisfaction? Friction at work or  
home? Coping strategies? Cultural and religious  
implications? Lifestyle impact?

Functional tests; comprehensive exam of affected part of  
the body compared to other side; exam of adjacent areas

Risk based on danger of condition and treatment; disability  
risk factors; work/school absence; opioid use

Review of past records, diagnostic tests, consultation  
reports and occupational information

Medical decision making also includes assessing risk for  
chronic work disability

Plan provides treatment of the presenting condition while  
also mitigating chronic work disability and managing return  
to optimal function in society

### Figure 1 – Function-Oriented Model

This figure illustrates the difference between the symptom-oriented model of documentation of the Evaluation and Management encounter and the ACOEM function-oriented model.

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# History

## Elements of the History

The following table lists the current CMS elements of a patient history in comparison to the proposed elements appropriate for a function-oriented encounter. In order to capture the myriad important psychosocial factors identified by research, we refined the elements of family history and social history to emphasize such risk factors. We also modified the Review of Systems to capture elements known to impact optimal functioning at home, society or work.

	CC	HPI	Past History	Family History	Social History	ROS
<b>CMS Elements</b>	Reason for the encounter	<ol style="list-style-type: none"> <li>1. Location</li> <li>2. Severity</li> <li>3. Timing</li> <li>4. Modifying factors</li> <li>5. Quality</li> <li>6. Duration</li> <li>7. Context</li> <li>8. Associated signs/symptoms</li> </ol>	<ol style="list-style-type: none"> <li>1. Current meds</li> <li>2. Drug allergies</li> <li>3. Prior surgeries</li> <li>4. Prior hospitalizations</li> <li>5. Prior major illnesses/injuries</li> <li>6. Immunizations</li> </ol>	<ol style="list-style-type: none"> <li>1. Health status or cause of death of near relatives</li> <li>2. Specific disease related to CC, HPI, ROS</li> <li>3. Relevant Hereditary Diseases</li> </ol>	<ol style="list-style-type: none"> <li>1. Occupational history</li> <li>2. Current employment</li> <li>3. Level of education</li> <li>4. Marital status or living arrangements</li> <li>5. Sexual history</li> <li>6. Habits (nutritional status; use of tobacco, alcohol or illicit drugs)</li> </ol>	<ol style="list-style-type: none"> <li>1. Constitutional</li> <li>2. Eyes</li> <li>3. Ears, nose, mouth, throat</li> <li>4. Cardiovascular</li> <li>5. Respiratory</li> <li>6. Gastrointestinal</li> <li>7. Genitourinary</li> <li>8. Musculoskeletal</li> <li>9. Skin</li> <li>10. Neurologic</li> <li>11. Psychiatric</li> <li>12. Hematologic or Lymphatic</li> <li>13. Allergic or immunologic</li> </ol>
<b>Function-Oriented Elements</b>	History of the injury or condition as relayed by the patient	<ol style="list-style-type: none"> <li>1. Location</li> <li>2. Severity (impact on function)</li> <li>3. Timing</li> <li>4. Modifying factors</li> <li>5. Quality</li> <li>6. Duration</li> <li>7. Context</li> <li>8. Associated signs/symptoms</li> </ol>	<ol style="list-style-type: none"> <li>1. Current meds</li> <li>2. Drug allergies</li> <li>3. Significant current illnesses under care</li> <li>4. Past injuries or conditions or surgeries relevant to the current injury/condition</li> <li>5. Past related workers' compensation claims</li> <li>6. Immunization status only if relevant</li> </ol>	<ol style="list-style-type: none"> <li>1. Work/Disability status of family members</li> <li>2. History of adverse childhood experiences</li> <li>3. Family/home situational stressors and supports</li> <li>4. Relevant Hereditary Diseases</li> </ol>	<ol style="list-style-type: none"> <li>1. Occupational history</li> <li>2. Current employment</li> <li>3. Work relationships and stressors</li> <li>4. Level of education</li> <li>5. Marital status or living arrangements</li> <li>6. Stress, sleep, coping</li> <li>7. Use of addictive substances</li> <li>8. Lifestyle (Nutrition, exercise, meditation, involvement in community)</li> </ol>	<ol style="list-style-type: none"> <li>1. Energy level</li> <li>2. Exercise capacity</li> <li>3. Sleep/snoring</li> <li>4. Attention/concentration</li> <li>5. Weight changes</li> <li>6. Appetite change</li> <li>7. Libido change</li> <li>8. Joint pain/swelling</li> <li>9. Headaches</li> <li>10. Numbness/tingling/weakness</li> <li>11. Depression/anxiety/worry</li> <li>12. Anger/irritability</li> </ol>

## Explanation of Function-Oriented HPI Elements

<u>Location</u>	What body part is involved? Where does it hurt? For illness, what system is involved?
<u>Severity</u>	Describe impact on activities at work or outside of work; consider using function scale; impact on activities of daily living
<u>Timing</u>	When was the onset? If symptoms followed an accidental injury, how long after? When are the symptoms worse or better?
<u>Modifying factors</u>	What makes it better or worse? How has the patient modified activities due to the condition?
<u>Quality</u>	Describe the character of the pain or other symptoms
<u>Duration</u>	How long have the symptoms lasted? If episodic, how long do they last when they occur?
<u>Context</u>	How did the injury or condition occur? Describe circumstances if work injury, work factors if gradual onset attributed to work, protective equipment.
<u>Associated signs/symptoms</u>	Other symptoms that may be related

## Level of History

The same criteria used by CMS are used for the function-oriented model.

CMS and Function-Oriented	CC	HPI	Past, Family, Social	ROS
<b>Problem-Focused</b>	Required	Brief (1-3 elements)	N/A	N/A
<b>Expanded Problem-Focused</b>	Required	Brief (1-3 elements)	N/A	Problem-Pertinent (affected system)
<b>Detailed</b>	Required	Extended (4 + elements)	Pertinent (minimum 1 item from any)	Extended (2 – 9 elements)
<b>Comprehensive</b>	Required	Extended (4 + elements)	Complete (minimum 1 item from each)	Complete (10 + elements)

# Physical Exam

## Physical Exam Bullets (CMS 1997 criteria)

The following table presents the 1997 CMS physical exam criteria. A comprehensive physical exam using CMS criteria includes many elements that are totally irrelevant to the presenting clinical problem, and the CMS criteria are missing many critical factors that should be examined, and would help evaluate the patient's risk and function. This CMS criteria table is followed by a proposed Occupational Medicine specialty musculoskeletal exam appropriate for a function-oriented exam.

Organ	CMS Criteria
Constitutional	1) Three vital signs      2) General appearance
Eyes	1) Inspection of conjunctivae and lids 2) Examination of pupils and irises (PERRLA) 3) Ophthalmoscopic discs and posterior segments
ENT/Mouth	1) External appearance of the ears and nose (overall appearance, scars, lesions, masses) 2) Otoscopic examination of the external auditory canals and tympanic membranes 3) Assessment of hearing 4) Inspection of nasal mucosa, septum and turbinates 5) Inspection of lips, teeth and gums 6) Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	1) Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) 2) Examination of thyroid
Respiratory	1) Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) 2) Percussion of chest (e.g., dullness, flatness, hyperresonance) 3) Palpation of chest (e.g., tactile fremitus) 4) Auscultation of the lungs
Cardiovascular	1) Palpation of the heart (location, size, thrills) 2) Auscultation of the heart with notation of abnormal sounds and murmurs 3) Assessment of lower extremities for edema and/or varicosities 4) Examination of the carotid arteries (e.g., pulse amplitude, bruits) 5) Examination of abdominal aorta (e.g., size, bruits) 6) Examination of the femoral arteries (e.g., pulse amplitude, bruits) 7) Examination of the pedal pulses (e.g., pulse amplitude)
Chest (Breasts)	1) Inspection of the breasts (e.g., symmetry, nipple discharge) 2) Palpation of the breasts and axillae (e.g., masses, lumps, tenderness)
GI	1) Examination of the abdomen with notation of presence of masses or tenderness 2) Examination of the liver and spleen 3) Examination for the presence or absence of hernias

	<p>4) Examination (when indicated) of anus, perineum, and rectum, including sphincter tone, presence of hemorrhoids, rectal masses</p> <p>5) Obtain stool for occult blood testing when indicated</p>
GU (male)	<p>1) Examination of the scrotal contents (e.g., hydrocoele, spermatoceole, tenderness of cord, testicular mass)</p> <p>2) Examination of the penis</p> <p>1) Digital rectal examination of the prostate gland (e.g., size, symmetry, nodularity, tenderness)</p>
GU (female)	<p>Pelvic examination (with or without specimen collection for smears and cultures, which may include:</p> <p>1) Examination of the external genitalia (e.g., general appearance, hair distribution, lesions)</p> <p>2) Examination of the urethra (e.g., masses, tenderness, scarring)</p> <p>3) Examination of the bladder (e.g., fullness, masses, tenderness)</p> <p>4) Examination of the cervix (e.g., general appearance, discharge, lesions)</p> <p>5) Examination of the uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)</p> <p>6) Examination of the adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)</p>
Lymphatic	<p>Palpation of lymph nodes <b>two</b> or more areas:</p> <p>1) Neck            3) Groin</p> <p>2) Axillae        4) Other</p>
Musculoskeletal	<p>1) Examination of gait and station</p> <p>2) Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)</p> <p>3) Examination of the joints, bones, and muscles of one or more of the following six areas:</p> <p>a) head and neck</p> <p>b) spine, ribs, and pelvis</p> <p>c) right upper extremity</p> <p>d) left upper extremity</p> <p>e) right lower extremity</p> <p>f) left lower extremity</p> <p>The examination of a given area may include:</p> <p>1) Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation,</p> <p>2) defects, tenderness, masses or effusions</p> <p>3) Assessment of range of motion with notation of any pain, crepitation or contracture</p> <p>4) Assessment of stability with notation of any dislocation, subluxation, or laxity</p> <p>5) Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movements</p>
Skin	<p>1) Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)</p> <p>2) Palpation of the skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)</p>
Neurologic	<p>1) Test cranial nerves with notation of any deficits</p> <p>2) Examination of DTRs with notation of any pathologic reflexes (e.g., Babinski)</p> <p>3) Examination of sensation (e.g., by touch, pin, vibration, proprioception)</p>
Psychiatric	<p>1) Description of patient's judgment and insight</p> <p>Brief assessment of mental status which may include</p> <p>1) orientation to time, place, and person    2) recent and remote memory    3) mood and affect</p>



## Specialty Exam: Occupational Medicine Musculoskeletal

Constitutional	<ul style="list-style-type: none"> <li>• Measurement of any 3 of these vital signs: heart rate, blood pressure; height, weight, calculated BMI.</li> <li>• General appearance (e.g. pain behavior, movement during visit, evidence for or against sedation)</li> </ul>		
Mental Status	<ul style="list-style-type: none"> <li>• Cognition (e.g. orientation to time, place, and person; insight and judgment; recent and remote memory; ability to provide a detailed history)</li> <li>• Mood/affect or cooperation level</li> </ul>		
Spine  Detailed Spine Exam =  At least 8 bullets  Count one bullet for spine level examined for a given bullet	<p>Detailed Spine Exam</p> <ul style="list-style-type: none"> <li>• Assessment of range of motion (flexion, extension, lateral bending and rotation) of involved and adjacent spine segments ___ C ___ T ___ L</li> <li>• Inspection/palpation/percussion: spinous processes for tenderness, any atrophy or fasciculations ___ C ___ T ___ L</li> <li>• Examination of joints just distal to the relevant spine area (e.g. shoulder if neck injury) ___ C ___ T ___ L</li> <li>• Sensation in the relevant dermatome (e.g., by touch, pin, vibration, proprioception) ___ C ___ T ___ L</li> <li>• Examination of deep tendon reflexes with notation of any pathologic reflexes (e.g., Babinski) ___ UE ___ LE</li> <li>• Examination of bilateral strength in the relevant area (for neck, check UEs; for back, check LEs) ___ UE ___ LE</li> <li>• Assessment of muscle tone (e.g. flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movements with bilateral circumferential measurements if difference is noted; or, tests related to balance or coordination; or bladder/anal sphincter laxity for r/o cauda equina) ___ UE ___ LE</li> <li>• Distraction, provocation or other special tests (e.g. straight leg raise and crossed straight leg raise) with description of findings (not positive or negative): _____</li> </ul>	Extremities  Detailed Extremity Exam =  At least 8 bullets  Count one bullet for each side examined	<p>Detailed Extremity Exam</p> <ul style="list-style-type: none"> <li>• Inspection for evidence of inflammation or chronic connective tissue disease, misalignment, asymmetry, rhythm of movement ___ RUE ___ LUE ___ RLE ___ LLE</li> <li>• Palpation of joints/limbs for crepitation, defects, tenderness, masses or effusion ___ RUE ___ LUE ___ RLE ___ LLE</li> <li>• Assessment of active and then passive range of motion with notation of any pain, crepitation or contracture in the affected joint ___ RUE ___ LUE ___ RLE ___ LLE</li> <li>• Assessment of active and then passive range of motion in the joints proximal to the injured joint (e.g. if wrist was injured, examine elbow movement on the affected side) ___ RUE ___ LUE ___ RLE ___ LLE</li> <li>• Assessment of active and then passive range of motion in the joints distal to the injured joint (e.g. if wrist was injured, examine thumb movement on the affected side) ___ RUE ___ LUE ___ RLE ___ LLE</li> <li>• Assessment of stability with notation of any dislocation, subluxation, or laxity; or assessment of muscle tone (e.g. flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movements with bilateral circumferential measurements if difference is noted ___ RUE ___ LUE ___ RLE ___ LLE</li> <li>• Assessment of strength, sensation or reflexes relevant to the affected extremity ___ RUE ___ LUE ___ RLE ___ LLE</li> <li>• Distraction, provocation or other special tests with description of findings (not positive or negative) _____</li> <li>___ RUE ___ LUE ___ RLE ___ LLE</li> </ul>
Related Organs	<ul style="list-style-type: none"> <li>• Examination of any of these areas: Cardiovascular; Pulmonary; Gastrointestinal; Endocrine; Renal; Reproductive; Dermatologic</li> </ul>		
Functional Assessment	<ul style="list-style-type: none"> <li>• Examination of gait, posture or balance</li> <li>• Ability to rise from chair or climb to/from table, with or without assistance of arms</li> <li>• Documentation of any of these: use of assistive devices; discrepancy between exam findings related to actual need for devices; tests or demonstration of ability to use affected body part (e.g. grip object, reach, squat); simulation of work activities</li> </ul>		

## Level of Exam Criteria

Because all the function-oriented exam elements are all relevant to a musculoskeletal injury or condition, scoring is much simpler for levels of care.

Level of Exam	CMS Criteria Performed and Documented	Function-Oriented Exam Performed and Documented
<b>Problem-Focused</b>	Limited to affected body area or organ system One to five bullets from one or more organ systems	One to five bullets
<b>Expanded Problem-Focused</b>	Affected body area or organ system Other symptomatic or related organ systems At least six bullets from any organ systems	Six to eleven bullets
<b>Detailed</b>	Extended examination of affected body areas Other symptomatic or related organ systems At least two bullets from six organ systems OR 12 <i>bullets</i> from two or more organ systems	Twelve or more bullets
<b>Comprehensive</b>	Complete single system specialty examination or Complete multi-system examination Two bullets from EACH of nine organ systems	Sixteen or more bullets, with detailed spine exam OR detailed extremity exam

# Medical Decision Making Criteria

## Complexity of Medical Decision Making

Complexity of medical decision making (MDM) takes into account the number of clinical problems (number of diagnoses or management options); the amount and complexity of data the clinician reviews; and the risk of complications, morbidity or mortality. The MDM criteria for function-oriented encounters are largely the same as the CMS criteria, with clarification of the types of problems, management options, data and risk that are relevant to care that promotes optimal social participation and functioning. The following is the CMS table for medical decision making level. This same schema can be used for function-oriented encounters, with some changes in the definition of the categories that inform. See the subsequent tables below for suggested modifications.

<b>Level of Complexity</b>	<b>Number of diagnoses or management options</b>	<b>Amount/complexity of data to be reviewed</b>	<b>Risk of complications, morbidity or mortality</b>
<b>STRAIGHTFORWARD</b>	Minimal	Minimal or None	Minimal
<b>LOW COMPLEXITY</b>	Limited	Limited	Low
<b>MODERATE COMPLEXITY</b>	Multiple	Moderate	Moderate
<b>HIGH COMPLEXITY</b>	Extensive	Extensive	High

## Medical Decision Making Criteria – CMS vs. Function-Oriented Criteria

The only difference between the CMS and Function-Oriented Criteria for medical decision making complexity is including work disability as a morbidity outcome.

Criterion	CMS Criteria	Function-Oriented Criteria
<b>STRAIGHTFORWARD</b>	<ul style="list-style-type: none"> <li>● Minimal number of diagnoses or management options</li> <li>● Minimal or no data to be reviewed</li> <li>● Minimal risk of complications, morbidity, mortality</li> </ul>	<ul style="list-style-type: none"> <li>● Minimal number of diagnoses or management options</li> <li>● Minimal or no data to be reviewed</li> <li>● Minimal risk of complications, morbidity (including work disability), mortality</li> </ul>
<b>LOW COMPLEXITY</b>	<ul style="list-style-type: none"> <li>● Limited number of diagnoses or management options</li> <li>● Limited amount or complexity of data to be reviewed</li> <li>● Low risk of complications, morbidity, mortality</li> </ul>	<ul style="list-style-type: none"> <li>● Limited number of diagnoses or management options</li> <li>● Limited amount or complexity of data to be reviewed</li> <li>● Low risk of complications, morbidity (including work disability), mortality</li> </ul>
<b>MODERATE COMPLEXITY</b>	<ul style="list-style-type: none"> <li>● Multiple diagnoses or management options</li> <li>● Moderate amount or complexity of data to be reviewed</li> <li>● Moderate risk of complications, morbidity, mortality</li> </ul>	<ul style="list-style-type: none"> <li>● Multiple diagnoses or management options</li> <li>● Moderate amount or complexity of data to be reviewed</li> <li>● Moderate risk of complications, morbidity (e.g. prolonged work disability)</li> </ul>
<b>HIGH COMPLEXITY</b>	<ul style="list-style-type: none"> <li>● Extensive diagnoses or management options</li> <li>● Extensive amount or complexity of data to be reviewed</li> <li>● High risk of complications, morbidity, mortality</li> </ul>	<ul style="list-style-type: none"> <li>● Extensive diagnoses (e.g. multiple past workers compensation claims) or management options</li> <li>● Extensive amount or complexity of data to be reviewed</li> <li>● High risk of complications, morbidity (e.g. prolonged work disability), mortality</li> </ul>

## Risk Level Table

Note that chronic work disability is considered a severe outcome, equivalent to loss of life or limb. Risk is based on highest level in any column, as in CMS system.

Risk Level	CMS Criteria			Function-Oriented Criteria for WC Injury or Illness		
	Presenting Problems	Diagnostic Procedures	Management Options Selected	Presenting Problems	WC Diagnostic Procedures	Management Options Selected
Minimal	One self-limited or minor problem	Laboratory tests Chest X-rays EKG/EEG Urinalysis Ultrasound/Echocardiogram KOH prep	Rest Gargles Elastic bandages Superficial dressings	One self-limited or minor problem	Laboratory tests X-rays Audiology EKG	Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated injury or illness	Physiologic tests not under stress Non-cardiovascular imaging studies with contrast Superficial needle biopsy ABG Skin biopsies	Over the counter drugs Minor surgery, with no identified risk factors Physical therapy Occupational therapy IV fluids, without additives	Two or more self-limited or minor problems One stable chronic condition Acute uncomplicated injury or illness	Physiologic tests not under stress (e.g. spirometry) Imaging studies other than X-rays, without contrast Allergy or skin patch testing	Over the counter drugs Work restrictions addressing only the injured body part Splints Physical therapy Occupational therapy Counseling on safe activities and self-care
Moderate	Two stable chronic illnesses One chronic illness with mild exacerbation or progression Undiagnosed new problem with uncertain prognosis Acute complicated injury	Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test Diagnostic endoscopies, with no identified risk factors Deep needle, or incisional biopsies Cardiovascular imaging studies, with contrast, with no identified risk factors, e.g., arteriogram, cardiac catheterization Obtain fluid from body cavity, e.g., LP/thoracentesis	Minor surgery, with identified risk factors Elective major surgery with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids, with additives Closed treatment of fracture or dislocation, without manipulation	Two stable chronic conditions One chronic condition with mild exacerbation or progression Undiagnosed new problem with uncertain prognosis Acute complicated injury Delayed injury recovery compared to estimated duration of disability Use of opioids past 30 days Work relationship problems Already off work, less than 4 weeks	Nerve testing Bone scans Imaging studies with contrast Functional capacity evaluation Physiologic tests under stress, e.g., cardiac stress test, pulmonary exercise test	Work restrictions addressing multiple body parts/functions Management of work accommodations, hazard abatement, equipment or ergonomic modifications Addressing environmental tests Joint aspiration or epidural injection Prescription drug management Closed treatment of fracture or dislocation, without manipulation Counseling on self-management for pain, disability risk factors, activities to support return-to-work
High	One or more chronic illness, with severe exacerbation or progression Acute or chronic illness or injury, which poses a threat to life or bodily function An abrupt change in neurological status	Cardiovascular imaging, with contrast, with identified risk factors Cardiac EP studies Diagnostic endoscopies, with identified risk factors Discography	Elective major surgery with identified risk factors Emergency major surgery Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate, or to de-escalate care	One or more chronic illness, with severe exacerbation/progression Acute or chronic illness or injury, which poses a threat to life, bodily function or return to work Presence of multiple disability risk flags Use of opioids past 60 days Off work more than 4 weeks Job/modified work not available	Methacholine challenge	Detailed determination of overall functional abilities related to permanent restrictions Collaboration with vocational rehabilitation Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity (including chronic opioid management or detoxification) Work-focused cognitive behavioral therapy Functional restoration program Multidisciplinary pain mgmt. program

## Risk for Chronic Work Disability

The proposed alternative risk table for function-oriented care includes clinical problems known to increase the risk of chronic work disability for patients in whom that is a consideration, including opioid use, already being off work, and presence of disability risk factors. Risk management strategies appropriate for mitigating these risk factors have been added to the “management options selected” column. This table can also serve to help determine whether the medical decision making is appropriate for the clinical problem level identified.

The treating provider must provide clear documentation of the rationale for attributing high risk for chronic work disability to a clinical situation.

Ideally, there should be evidence of screening for evidence-based risk categories: adverse childhood experiences (ACE); yellow flags for pain behavior, disability beliefs, catastrophization, fear/avoidance; blue flags for problems between the worker and workplace; black flags for systemic barriers to return-to-work such as employer policy; orange flags for mental illness. ([http://www.physio-pedia.com/The\\_Flag\\_System](http://www.physio-pedia.com/The_Flag_System)) The management plan should address mitigation of the identified risk factors, including an evidence-based opioid management plan when opioids are used.

Vocational assessment should be addressed at the first meeting with a patient, with planning to optimize function (return-to-work, return-to-school, or other similar outcomes representing full participation in society) and be updated at each additional visit. Because a prolonged period of time off work will decrease the likelihood of return to work, the first weeks of treatment are crucial in preventing and/or reversing chronicity and disability mindset.

The World Health Organization Disability Assessment Schedule 2.0 <http://www.who.int/classifications/icf/whodasii/en/> provides a useful model for characterizing the impact of a condition on a patient’s function in multiple domains:

- Cognition – understanding and communicating
- Mobility – moving and getting around
- Self-care – hygiene, dressing, eating and staying alone
- Life activities – domestic responsibilities, leisure, work and school
- Participation – joining in community activities

### References:

Early Identification and Management of Psychological Risk Factors (“Yellow Flags”) in Patients with Low Back Pain: A Reappraisal. Nicholas MK, Linton SJ, Watson PJ, Main CJ, “Decade of the Flags” Working Group. *Physical Therapy*, May 2011 Vol 91 (5): 737-753.

Early Patient Screening and Intervention to Address Individual-Level Occupational Factors (“Blue Flags”) in Back Disability. Shaw WS, Van der Windt DA, Main CJ, Loisel P, Linton SJ, “Decade of the Flags” Working Group. *Journal of Occupational Rehabilitation*, 2009, Vol 19: 64-80.

# Medical Decision-Making Point System

## Problem Points

For CMS auditing purposes, a point system was developed and piloted by the Marshfield Clinic, to help quantify the nebulous criteria for nature and number of clinical problems (minimal, limited, multiple, extensive). This auditing point system was distributed by CMS to Medicare carriers. The “nature and number of clinical problems” are quantified into Problem Points by referring to the following table. Note that a long-standing problem can still be considered a new problem if it is new to the examiner. Points are added, but the maximum is 4.

For this table, the function-oriented criteria are essentially the same as CMS criteria, but different examples are given for typical occupational health encounters.

CMS Criteria	Function-Oriented Criteria	Examples Relevant to Occupational Medicine Practice	Points
Self-limited or minor	Self-limited or minor	Jammed finger or wrist sprain	1
Established problem, stable or improving	Established problem, stable or improving	Stable depression, under treatment; previous separate injury to the same body part, improving	1
Established problem, worsening	Established problem, worsening	Knee osteoarthritis, with worse symptoms or swelling	2
New problem, no additional work-up needed	Established or new patient with a new problem, no additional work-up needed	Allergic reaction to the materials in a splint or elastic bandage	3
New problem, with additional work-up needed	Established or new patient with a new problem, with additional work-up needed	Any new clinical or vocational issue which requires further investigation such as new symptoms suggesting misdiagnosis (e.g. shoulder injury now presenting with radicular symptoms warranting need for cervical spine imaging) or need for clarification of job tasks, hazards, demands or personal protective equipment needed.	4

## Data Points

The following table shows the CMS Criteria and Function-Oriented alternative criteria for data points, to score the amount and complexity of the data reviewed.

CMS Criteria for Data Reviewed	Function-Oriented Criteria Including Occupational Information	Points
Review or order clinical lab tests	Review or order clinical lab tests	1
Review or order radiology test (except heart catheterization or echo)	Review or order radiology test	1
Review or order medicine test (PFTs, EKG, cardiac echo or catheterization)	Review or order PFT, EKG, Audiogram	1
Discuss test with performing physician	Discuss test with performing physician or discuss work tasks or restrictions with stakeholder (e.g. employer)	2
Independent review of image, tracing, or specimen	Independent review of image, tracing, or specimen	2
Decision to obtain old records	Identify and request needed additional records, including job-related	1
Review and summation of old records	Review and summation of old records, including exposure records	2



## Calculating Cognitive Labor Using Medical Decision-Making Points System

There is no difference between the CMS and Function-Oriented criteria for medical decision making. Note 2 out of 3 must be present to qualify for a given level.

Level of Complexity of Medical Decision Making	Problem Complexity		Data Complexity		Risk
	Number of diagnoses or management options	Problem Points	Amount/complexity of data to be reviewed	Data Points	Risk of complications, morbidity or mortality
Straightforward Complexity	Minimal	1	Minimal or None	1	Minimal
Low Complexity	Limited	2	Limited	2	Low
Moderate Complexity	Multiple	3	Moderate	3	Moderate
High Complexity	Extensive	4	Extensive	4	High

## Problem Severity Criteria

Problem severity is one of the separate criteria used in determining the level of care by CMS. There is a lot of overlap with Medical Decision-Making criteria. Criteria are the same for CMS and Function-Oriented, except that Function-Oriented criteria also consider risk of work disability as a measure of morbidity.

Nature of Problem	CMS Criteria	Function-Oriented Criteria
<b>Minimal</b>	<ol style="list-style-type: none"> <li>1. Problem does not require physician presence</li> <li>2. Service provided under supervision of a physician</li> </ol>	<ol style="list-style-type: none"> <li>1. Problem does not require physician presence</li> <li>2. Service provided under supervision of a physician</li> </ol>
<b>Self-limited or minor 2 out of 3</b>	<ol style="list-style-type: none"> <li>1. Minimal number of diagnoses or management options</li> <li>2. Minimal or no data to be reviewed</li> <li>3. Minimal risk of complications, morbidity, mortality</li> </ol>	<ol style="list-style-type: none"> <li>1. Minimal number of diagnoses or management options</li> <li>2. Minimal or no data to be reviewed</li> <li>3. Minimal risk of complications, morbidity (e.g. work disability), mortality</li> </ol>
<b>Low severity 2 out of 3</b>	<ol style="list-style-type: none"> <li>1. Limited number of diagnoses or management options</li> <li>2. Limited amount or complexity of data to be reviewed</li> <li>3. Low risk of complications, morbidity, mortality</li> </ol>	<ol style="list-style-type: none"> <li>1. Limited number of diagnoses or management options</li> <li>2. Limited amount or complexity of data to be reviewed</li> <li>3. Low risk of complications, morbidity (e.g. work disability), mortality</li> </ol>
<b>Moderate severity 2 out of 3</b>	<ol style="list-style-type: none"> <li>1. Multiple diagnoses or management options</li> <li>2. Moderate amount or complexity of data to be reviewed</li> <li>3. Moderate risk of complications, morbidity, mortality</li> </ol>	<ol style="list-style-type: none"> <li>1. Multiple diagnoses or management options</li> <li>2. Moderate amount or complexity of data to be reviewed</li> <li>3. Moderate risk of complications, morbidity (e.g. work disability), mortality</li> </ol>
<b>High severity 2 out of 3</b>	<ol style="list-style-type: none"> <li>1. Extensive diagnoses or management options</li> <li>2. Extensive amount or complexity of data to be reviewed</li> <li>3. High risk of complications, morbidity, mortality</li> </ol>	<ol style="list-style-type: none"> <li>1. Extensive diagnoses or management options</li> <li>2. Extensive amount or complexity of data to be reviewed</li> <li>3. High risk of complications, morbidity (e.g. work disability), mortality</li> </ol>

## Coding Requirements for New Patient Encounters

Coding new patient encounters in using function-oriented criteria would use the same requirements as current CMS rules for type of encounter.

Type of Encounter	AMA CPT Code	CMS CPT Requirements	Example
New patient, simple	99201	A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. SELF-LIMITED OR MINOR PROBLEM. PHYSICIAN TIME 10 MINUTES.	Contusion of finger in a door
New patient, straightforward	99202	AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. LOW SEVERITY OR MODERATE SEVERITY PROBLEM. PHYSICIAN TIME 20 MINUTES.	Landscaper with a puncture wound to the foot
New patient, detailed	99203	A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. MODERATE SEVERITY PROBLEM. PHYSICIAN TIME 30 MINUTES.	Fall at work resulting in low back pain and visible contusion
New patient, moderately complex	99204	A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. MODERATE OR HIGH SEVERITY PROBLEM. PHYSICIAN TIME 45 MINUTES.	Ankle injury in patient with arthritis and past knee injury
New patient, high complexity	99205	A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. MODERATE OR HIGH SEVERITY PROBLEM. PHYSICIAN TIME 60 MINUTES.	Shoulder injury with radicular symptoms, on opioids from other doctor for 2 months

## Coding Requirements for Established Patient Encounters

Coding established patient encounters using function-oriented criteria would use the same requirements as current CMS rules for type of encounter.

Type of Encounter	AMA CPT Code	CMS CPT Requirements	Example
Established patient*, simple	99211	MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES. MINIMAL PROBLEM. STAFF TIME 5 MINUTES.	Follow-up minor laceration
Established patient, straightforward	99212	AT LEAST 2 OF THESE 3 KEY COMPONENTS: (A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING.) SELF-LIMITED OR MINOR PROBLEM. PHYSICIAN TIME 10 MINUTES.	Follow-up resolved contusions
Established patient, detailed	99213	AT LEAST 2 OF THESE 3 KEY COMPONENTS: (AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY.) LOW OR MODERATE SEVERITY PROBLEM. PHYSICIAN TIME 15 MINUTES.	Follow-up wrist sprain
Established patient, moderately complex	99214	AT LEAST 2 OF THESE 3 KEY COMPONENTS: (A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY.) MODERATE OR HIGH SEVERITY PROBLEM. PHYSICIAN TIME 25 MINUTES.	Neurologic symptoms suggesting carpal tunnel syndrome after wrist sprain
Established patient, high complexity	99215	AT LEAST 2 OF THESE 3 KEY COMPONENTS: (A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY.) MODERATE OR HIGH SEVERITY PROBLEM. PHYSICIAN TIME 40 MINUTES.	Back strain complicated by depression and opioid dependence

## Summary

The proposed modified criteria for E/M encounters will promote better clinical management consistent with patient-centered medical care, while appropriately paying clinicians for the cognitive work involved in preventing suboptimal functional outcomes. The specific changes that accomplish this are:

- History elements to include functional impact and risk for chronic disability
- Physical examination to identify and document findings that have an impact on function
- Medical decision-making to include mitigating risk for chronic disability
- Problem severity adjusting for psychosocial factors that impact functional recovery (substance abuse, disability beliefs, etc.)

These proposed criteria work within the established parameters for codes and levels of care for new and established patients, and should be easy to adopt without major system modifications.

ACOEM believes that it is time to shift clinical attention to the functional impact of conditions, and to mitigating problems that hinder a patient's full participation in society, whether that is work, school, active retirement, or other ways of fully engaging in life and society. Such a shift will make care more patient-centered, reduce excessive medical costs related to the quest for symptom reduction, reduce patient harm related to unnecessary medical care, and should help stem the rising costs related to Social Security Disability.