

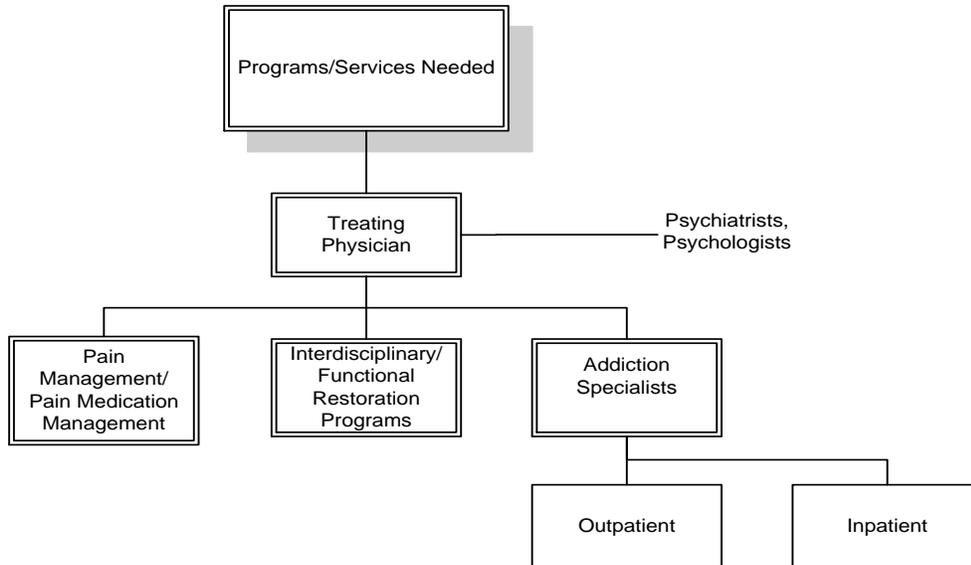
**Implementation and Process  
Recommendations  
for the New York  
Non-Acute Pain  
Medical Treatment Guidelines**



April 3, 2013

## Program/service availability

What are the programs/services that are needed to fulfill the recommendations of the Non-Acute Pain MTG?



### Recommendation:

#### I. Identify and recruit qualified professionals

- Treating physicians
- Psychiatrists/Psychologists: to perform clinical psychosocial evaluation and treatment
- Pain Management specialists
- Addiction Management specialists

#### II. Develop Functional Restoration Programs (FRP)

Functional Restoration Programs are recommended in the Non-Acute Pain MTG (E.3) and should be used in the management of appropriate patients with non-acute pain.

- Limited programs available in NY
- Look at exiting models
  - NYU model
  - Washington State (regulation)
- Identify resources necessary for the development and implementation of FRP programs.

#### III. Identify Addiction Medicine Specialists (outpatient and inpatient services)

- New York State Office of Alcoholism and Substance Abuse Services (OASAS) [www.oasas.ny.gov/](http://www.oasas.ny.gov/)
- Private physicians certified in addiction medicine
- American Society of Addiction Medicine ([www.asam.org/](http://www.asam.org/)) and New York Society of Addiction Medicine ([www.nysam-asam.com/](http://www.nysam-asam.com/))

**IV. Recommendation: Determine adequate fee structure to compensate physicians**

- Performing comprehensive evaluations and re-evaluations
- Developing and implementing an appropriate treatment plan and monitoring
- Opioid assessments and monitoring (therapeutic trials, risk assessment, opioid agreements)
- Job site evaluation (General Principle A.19)

**IV. (a) Recommendation: suggested Evaluation and Management (E&M) Criteria for Non-Acute Pain Workers' Compensation Documentation**

See framework below for Non-Acute Pain E&M documentation (modified from Colorado)

*New Patient/Office Consultations*

The Non-Acute Pain MTG details elements to be included in the history taking and physical examination which fulfill requirements to qualify for a comprehensive level of service (Non-Acute Pain MTG Sections D.1, D.3, E and F).

A physician who fully completes a comprehensive evaluation for a new patient, including all the elements as detailed in the Non-Acute Pain MTG should be entitled to payment for a Level 5 E&M office visit/consultation code (CPT 99215/99245).

Level of Service (Requires all three key components)	1. History	2. Exam	3. Medical Decision Making (MDM)
Comprehensive	All elements (D.1.a, D.1.b, D.1.d)	All elements (D.1.c, D.1.d)	High complexity (D.3, E and F)

D.1.a. Pain history, history of present illness

D.1.b Past medical history

D.1.c Physical exam

D.1.d Evaluation for red flags

D.3 Diagnostic studies

E. Non-pharmacologic approaches

F. Pharmacological approaches

*Established Patient Office Visit*

Documentation must be patient specific and pertain directly to the current visit. All documentation must accurately reflect the work performed during the encounter.

A physician who fully completes a detailed or comprehensive evaluation for an established patient, including all the elements as detailed in the table below should be entitled to payment for a Level 4 (Detailed) or 5 (Comprehensive) E&M office visit code (CPT 99214 or 99215).

Component	Detailed	Comprehensive
History	Minimum 8 elements pain, minimum 3 elements function	9 or more elements pain, minimum 3 elements function
System review	Both elements	Both elements
Psychosocial/Work History	Minimum 2 elements	All 3 elements
Physical Examination	Up to 5 elements	6 or more elements
Medical Decision Making (MDM)	Up to 7 elements	8 or more elements
Counseling	See below	
Coordination of care	See below	

NOTE: Documentation of a chief complaint is required for any office visit.

**1. History component:** To qualify for a given level of visit, the elements below must be documented in the medical record, including a detailed description of the patient's progress since the last visit with current treatment plan that includes patient pertinent objective functional gains, such as ADLs, physical therapy goals and return to work.

A. Pain

- Location (where?)
- Quality (sharp, dull)
- Severity (pain scale)
- Duration (how long?)
- Timing (how often?)
- Change in severity over time (review pain scales)
- Context (what work activities, ADLs or functions aggravate or relieve pain?)
- Modifying factors (what?)
- Associated symptoms (e.g., nausea, when?)
- Medications
- Psychosocial Functioning
- Treatment Expectations

B. Function

- Change in function with treatment (identify specific work activities or ADLs that have improved, remain the same or worsened)
- Identify what makes functional abilities better or worse
- Expected specific functional goals
- Review of functional instruments, as relevant

## 2. System review

- A. Review of systems for systemic repercussion of non-acute pain and secondary effects of medication in other organs/systems
- B. Review for red flags or other medical conditions that may account for lack of improvement

## 3. Psychosocial /work history

- Social/family situations that can interfere with or support the injured worker's treatment plan and returning to work
- Occupational history – current work status, any work situations that support or interfere with return to work, specific updates of progress, address progress of restrictions/ limitations at work.
- Non-Occupational/social history – Update on ADLs (specific updates of progress, address progress of restrictions/ limitations at ADLs), patient's support relationships, other physical activities such as hobbies, recreation, etc.

## 4. Physical Examination Component – Each element is counted only when it is pertinent and related to the current visit and the medical decision making process. All documentation must accurately reflect the work performed during the encounter.

### A. Vital signs/general inspection – minimum three count as one element:

Vital signs (may be measured and recorded by ancillary staff)

- Blood pressure (additional positional measurement of blood pressure as indicated)
- Pulse rate and regularity
- Respiration
- Temperature
- Height, weight or BMI
- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming, gait, posture, stance)

### B. Musculoskeletal

Four assessments for each body area are counted as one element; more than four assessments count as two elements.

Body area:

- Head and/or neck
- Mid and lower spine and pelvis
- Right upper extremity (shoulder, elbow, wrist, entire hand)
- Left upper extremity (shoulder, elbow, wrist, entire hand)
- Right lower extremity (hip, knee, ankle, entire foot)
- Left lower extremity (hip, knee, ankle, entire foot)

Assessment of a given body area includes:

- Inspection, percussion and/or palpation with notation of tenderness, crepitation misalignment, asymmetry, defects, masses or swelling, spasm, trigger points
- Assessment of range of motion with notation of any pain, crepitation or contracture
- Assessment of stability with notation of any dislocation, subluxation or laxity
- Examination of gait and station

- Provocative maneuvers
- Functional activities

C. Neurological

Minimum of three of the following neurological examination/assessments count as one element; four or more count as two elements:

- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)
- Motor evaluation (station, gait, coordination)
- Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities)
- Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
- Neurological maneuvers (nerve tension testing)
- One element for all of the 12 cranial nerves assessments, if indicated

D. Sensory evaluation

Each assessment counts as one element

- Examination of sensation (e.g., by touch, pin, vibration, proprioception)
- Quantitative sensory testing (i.e., monofilament testing)

E. Psychiatric

Each assessment counts as one element

- Assessment of mood and affect (e.g., depression, anxiety, agitation), including the use of at least one validated instrument, counts as one element
- One element for a mental status examination which includes:
  - Attention span and concentration; and
  - Language (e.g., naming objects, repeating phrases, spontaneous speech)
  - Orientation to time, place and person; and
  - Recent and remote memory; and
  - Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

F. Evaluation of non-physiologic findings – counts as one element

G. Additional general physical exam as indicated – counts as one element

**5. Medical Decision Making( MDM)**

Documentation must be patient specific and pertain directly to the current visit. All documentation must accurately reflect the work performed during the encounter.

A. Category of diagnosis and problems:

The first two bullets represent lower E&M codes and are not addressed in this document.

- Established diagnosis, stable or improved
- Established diagnosis, minor worsening

The third bullet counts as one element; the fourth bullet counts as two elements:

- New diagnosis with minor additional workup/treatment planned or established patient with worsening of condition and minor additional workup/treatment planned
- New diagnosis, additional workup/treatment planned or established patient with worsening of condition or additional workup/treatment planned

**B. Complexity of Data Reviewed**

Each one of the following counts as one element

- Prescription drug management, may include:
  - Perform and interpret office-based UDT according to MTG
  - Interpret confirmatory drug tests.
- Lab test(s) ordered and/or reports reviewed
- X-ray(s) ordered and/or reports reviewed
- Opioid risk assessment/stratification, if indicated
- Administer Patient Understanding for Opioid Treatment Form and Patient Informed Consent for Opioid Treatment Form
- Review/discuss Patient Understanding for Opioid Treatment Form and Patient Informed Consent for Opioid Treatment Form
- Review Ongoing Self-Management Plan
- Modify Ongoing Self-Management Plan
- Order physical therapy and/or review PT reports
- Comment on progress (state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care including detailed functional improvement plan)
- Potential for significant permanent work restrictions or total disability

Each one of the following counts as two elements:

- Management of addiction behavior or other significant psychiatric condition
- Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological /findings or verified related medical diagnosis.
- If patient not improving:
  - Reconsider the working diagnosis
  - Identify and document psychosocial risk factors which impact recovery
  - Identify primary psychiatric condition
  - Consider referral to mental health professional

*Counseling*

<b>Level of visit</b>	<b>Physician's time spent at E&amp;M visit</b>
Detailed	30-45 min
Comprehensive	46 -60 min

If greater than fifty percent of a physician's time at an E&M visit is spend face-to-face counseling and there is detailed patient specific documentation of the counseling, then time can determine the level of service. The total time spent with the patient, including time spent face-to-face counseling the patient and the visit time must be documented in the record. Documentation must be patient specific and pertain directly to the current visit. All documentation must accurately reflect the work performed during the encounter.

Counseling includes one or more of the following:

- Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan.
- Self-management of symptoms while at home and/or work
- Return to work, including all of the following:
  - Temporary and/or permanent restrictions
  - Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)
  - Correct posture/mechanics to perform work functions
  - Job task exercises for muscle strengthening and stretching
  - Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition
- Patient/injured worker expectations and specific goals
- Family and other interpersonal relationships and how they relate to psychological/social issues
- Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems)

*Coordination of Care*

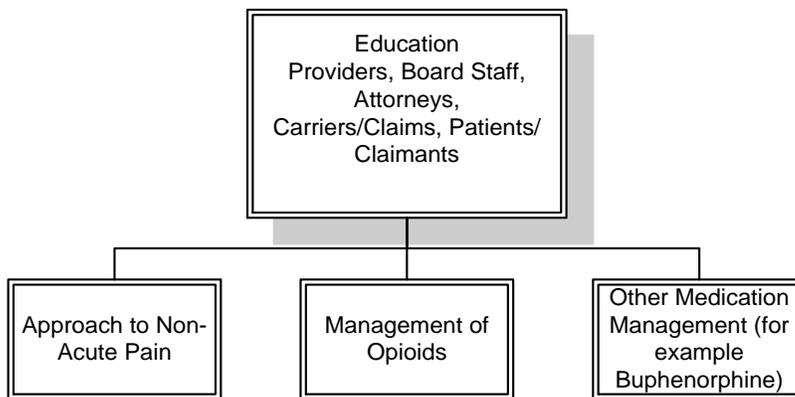
**Coordination of Care (99441, 99442, 99443)**

- Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient’s diagnosis and/or treatment or the physician telephones or visits the employer in person to safely return the patient to work.
- The counseling or coordination of care activities must be done 24 hours prior to the actual patient encounter or within seven business days after the actual patient encounter and should be properly and specifically documented and expanded in the medical record.

<b>Level of visit</b>	<b>Physician’s time</b>
99441	5-10 min
99442	11-20 min
99443	21-30 min

**V. Recommendation: education for all of the following**

- Physicians
- Other medical providers
- Attorneys
- Carriers and Third Party Administrators (TPA)
- Patients (including links to patient material)
- Board Staff (including WCLJ, Arbitrators, Conciliators, Medical Director’s Office, HPA staff, Claims staff)



- Type
- Who
- CME and other accreditation
- Mandatory for WCB staff, strongly recommended for physicians
- Don't reinvent the wheel (link to other training- REMS, OASAS, SAMSHA, other).
- Benefit from taking courses

**VI. Compliance with Federal and State laws and regulations (for example I-Stop legislation in NY when implemented)**

**VII. Recommendation: Balance best practices for Urine Drug Testing (UDT) and maintain confidentiality of UDT results**

When used with the appropriate level of understanding, UDT can improve the physician's ability to safely manage opioid therapy. However, controls need to be in place to protect against the inappropriate use of the results.

In recognizing the need to balance the value of UDT while protecting the confidentiality of the results, measures should be identified and implemented to limit the inappropriate exposure of these results. The MAC developed criteria that it believes permit UDT and at the same time provide a barrier against inappropriate use. The MAC wishes to emphasize the need for vigilance in UDT to insure both appropriate management of chronic opioid therapy and appropriate use of the test results. The criteria developed are:

- The patient has the right to refuse a urine drug test, but will receive no prescription for opiate medication as a consequence of the refusal
- The UDT results are not to be released to the carrier, employer or to the Board. However, the treating physician must certify the patient's adherence to or noncompliance with the Patient Understanding for Opioid Treatment Form and Patient Informed Consent for Opioid Treatment Form in the medical record.
- Employers cannot use test results to fire or discipline a worker in any discriminatory manner
- The recommendations in the Non-Acute Pain MTG do not apply to acute care situations.
- Guideline-specified criteria will be used to determine when and at what frequency UDT should be used.

**VIII. Recommendation: Data collection**

- Develop mechanisms to identify, collect and analyze data to assess the impact of the Non-Acute Pain MTG.

**IX. Recommendation: Feedback**

- Develop a mechanism to receive and respond to feedback from all stakeholders.
- Publicize the availability of the Medical Director's Office (MDO) mailbox for comments and/or questions.