Traditional Medicine Standard Terminology: Bridge to the ICD-11 Billing Practice

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Syllabus

COURSE LEARNING OUTCOMES: Through the successful completion of this course, each student will be able to:

- Understand the importance of standard terminology.
- Identify resources for standard terminology reference.
- Understand the purpose of ICD-11 Chapter 26 (TM1).
- Diversify the WHO International Standard Terminology pertaining to a specific style of Traditional Medicine including but not limited to Japanese, Korean, Five Element, Famous Masters, Scalp, etc.
- Parallel current ICD-10 and/or future ICD-11 billable diagnosis to NON-billable Traditional Medicine (TM1) pattern diagnosis.
- Formulate treatment principle adapted to a specific style of Traditional Medicine using WHO International Standard Terminology.
- Implement general principles & rules for coding Traditional Medicines in compliance with USA insurance billing requirements.
- Write a SOAP note adapted to a specific style of Traditional Medicine using WHO International Standard Terminology in the standardized format.

TRADITIONAL MEDICINE

ICD-11 Chapter 26 (TM1)

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ICD-11 is now available for implementation,

following its adoption at the World Health Assembly on 25 May 2019

"All elements of ICD11 are available on https://icd.who.int and readers are encouraged to take a virtual tour, and gain hands-on experience."

https://icd.who.int/docs/ICD-11%20Implementation%20or%20Transition%20Guide_v105.pdf

ICD-11 Chapter 26 ™ History

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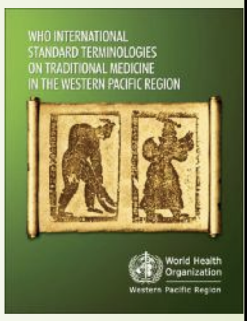
WHO completed a survey among member nations and discovered that 82% of the world's population uses some form of Traditional Medicine (2012)

- In 1972, WHO established a Department of Traditional Medicine (DTM).
- In 1978, the Alma-Ata Declaration on Primary Health Care called on countries and governments to include the practice of TM within their primary health care approaches
- In 1991, after 10 years of working, the proposed Standard International Acupuncture Nomenclature was published by WHO.
- In 2003 The proposed TM project started in 3 sections and timing stages: (1) standardization of the acupuncture points, (2) standardized term set, and (3) assignment of diagnostic codes.
- In 2005, Dr Choi reached out to what is now the American Association of Acupuncture and Oriental Medicine for US representation.
- In 2007 WHO published WH"O international standard terminologies on traditional medicine in the Western Pacific Region" manual
- In 2011 The review of the alpha version of the ICTM-11 began. The working language is English, and the translation is not word-for-word but rather based on concepts.
- 05/25/2019 ICD-11 including Chapter 26 ™ is released for implementation



https://apps.who.int/iris/handle/10665/206952

International Classification of Traditional Medicine
William Morris, PhD, DAOM;
Stacy Gomes, EdD;
Marilyn Allen, MS
www.gahmj.com •
September 2012 • Volume 1 Number 4

The United States is potentially one of the largest users of Traditional Medicine.

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worldometers.info/world-population/population-by-country/

Countries in the world by population (2020)

This list includes both **countries** and **dependent territories**. Data based on the latest *United Nations Population Division* estimates.
Click on the name of the country or dependency for current estimates (live population clock), historical data, and projected figures.
See also: World Population

Search:

#	Country (or dependency)	Population (2020)	Yearly Change	Net Change	Density (P/Km²)	Land Area (Km²)	Migrants (net)	Fert. Rate	Med. Age	Urban Pop %	World Share
1	China	1,439,323,776	0.39 %	5,540,090	153	9,388,211	-348,399	1.7	38	61 %	18.47 %
2	India	1,380,004,385	0.99 %	13,586,631	464	2,973,190	-532,687	2.2	28	35 %	17.70 %
3	United States	331,002,651	0.59 %	1,937,734	36	9,147,420	954,806	1.8	38	83 %	4.25 %
4	Indonesia	273,523,615	1.07 %	2,898,047	151	1,811,570	-98,955	2.3	30	56 %	3.51 %
5	Pakistan	220,892,340	2.00 %	4,327,022	287	770,880	-233,379	3.6	23	35 %	2.83 %
6	Brazil	212,559,417	0.72 %	1,509,890	25	8,358,140	21,200	1.7	33	88 %	2.73 %

TCM medicine use comparison US versus China

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China

- In 2006, there were 166,614 TCM practitioners in hospitals and 7843 TCM practitioners in community health centers [12]. Today (2019),
- TCM practitioners make up around 12% of all licensed doctors
- According to the China Health Statistics Yearbook 2018, there are 2641 million visits to Chinese traditional medicines (TCM) practitioners in the year 2017,
- which is about 32.3% of total visits to medical practitioners
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6787663/pdf/geriatrics-04-00049.pdf

US

- the number of licensed acupuncturists in 2015 in the U.S. was 34 481. Of this, more than 50% were licensed in three states alone: CA (32.39%), NY (11.89%) and FL (7.06 %).
- This is less than 4% of all US physicians
- In 2015, there were approximately 827,260 active doctors of medicine in patient care in the United States.
- In 2016 in the US were 883.7 million visits to the healthcare providers
- 10 million acupuncture treatments are administered annually in the US (2014)
- Which is about 0.1%
- https://www.asacu.org/wp-content/uploads/2019/02/NCCAOM-ASA-Appendices-CMS-Low-Back-call-for-comments-Feb-2019.pdf
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4104560/

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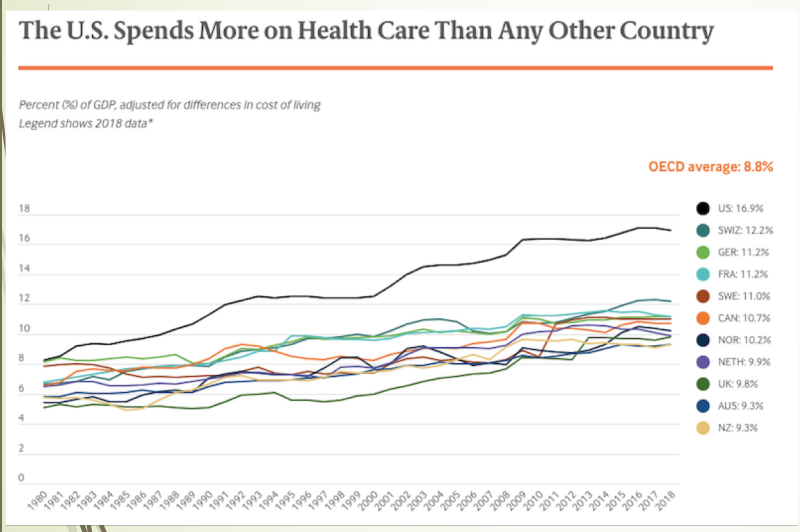
Motivation behind TM acceptance



- The single common denominator across the disciplines and between sovereign nations is the cost of medical care.
- Whether nationalized or privatized, there is a direct impact upon gross national product and the health of a nation.
- Furthering the prospect of medical integration and convergence of worldviews will be substantively enhanced through cost-of-care studies.
- The ICD-11 and the ICTM will enhance the prospects of such research.

https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

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Failed Back Surgery Syndrome

- Low back pain (LBP) has been estimated to have a lifetime prevalence of 60%–80% among the global population, making it one of the most common health complaints [1]. Approximately 10% of individuals suffering from LBP have symptoms that persist for longer than 3 months [2].
- Between 1998 and 2008, the yearly number of lumbar fusion surgeries performed in the United States increased from 77,682 to 210,407, with the total number of spinal operations exceeding one million in 2002 [7,8]. **The direct yearly cost of spinal fusion surgery in the United States was over US $16 billion in 2004** [9], whereas the overall **failure rate** of lumbar spine surgery was estimated to be **10%–46%** [10].
- Given that these rates have not changed substantially over the years despite advances in technology and surgical technique, the number of patients developing FBSS can be expected to continually increase [11].
- Repeat spinal surgery is a treatment option with diminishing returns. Although more than 50% of primary spinal surgeries are successful, no more than 30%, 15%, and 5% of the patients experience a successful outcome after the second, third, and fourth surgeries, respectively

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5913031/

Pharmaceutical Drugs

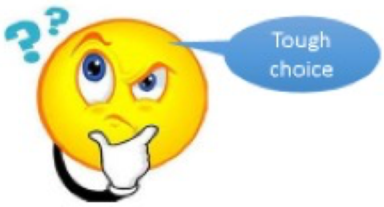
Year	Death	Serious
1971	698	8,905
1981	1,284	5,985
1991	4,459	56,322
2001	23,777	146,297
2006	37,309	264,227
2011	98,469	572,992
2016	142,099	831,991
2018	196,749	1,107,848
2019	173,8757	1,159,948

Source: FDA Adverse Events Reporting System (FAERS) Public Dashboard

https://fis.fda.gov/sense/app/d10be6bb-494e-4cd2-82e4-0135608ddc13/sheet/7a47a261-d58b-4203-a8aa-6d3021737452/state/analysis

Chinese Herbs

	Year	Death
Ma Huang (USA)	1995 - 2004	81
Guǎng Fáng Jǐ (Belgium)	1990 - 1994	102
Aconite (USA)	2017	1



Source: http://https//www.citizen.org/article/petition-requesting-ban-of-ephedra/

JL. Vandeherweghem. Misuse of Herbal Remedies: The Case of an Outbreak of Terminal Renal Failure in Belgium (Chinese Herbs Nephropathy). The Journal of Alternative and Complementary MedicineVol. 4, No. 1

https://www.cnn.com/2017/03/21/health/poisoned-herbal-tea-death-san-francisco/index.html

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ICD purpose and uses

The ICD is the foundation for the identification of health trends and statistics globally. It is the international standard for defining and reporting diseases and health conditions. It allows the world to compare and share health information using a common language.

The ICD defines the universe of diseases, disorders, injuries and other related health conditions. These entities are listed in a comprehensive way so that everything is covered. It organizes information into standard groupings of diseases, which allows for:

- easy storage, retrieval and analysis of health information for evidenced-based decision-making;
- sharing and comparing health information between hospitals, regions, settings and countries; and
- data comparisons in the same location across different time periods.
- It is the diagnostic classification standard for all clinical and research purposes. These include monitoring of the incidence and prevalence of diseases, observing reimbursements and resource allocation trends, and keeping track of safety and quality guidelines.
- ICD allows the counting of deaths as well as diseases, injuries, symptoms, reasons for encounter, factors that influence health status, and external causes of disease.

https://www.who.int/classifications/icd/factsheet/en/#:~:text=ICD%20purpose%20and%20uses,information%20using%20a%20common%20language.

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WHO strategies

- TM is a significant part of healthcare that is commonly used around the world;
- current health information systems about TM are not adequate: "Traditional medicine does not count, unless we count traditional medicine";
- local TM knowledge exists, but there is a lack of international harmonization;
- international standardization of TM information is essential;
- unification of traditional medicine and conventional information will improve efficiency; and
- digitalization of health information provides an opportunity for TM.

WHO is coordinating various streams of work to develop standardized TM terminology and the classification system. This standardization will allow for regular data collection and comparisons with conventional health information systems.

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3.6 Traditional Medicine conditions - Module 1 (TM1)

Traditional Medicine (TM) is an integral part of health services provided in many countries. National authorities have not had proper methods, nationally or internationally, to monitor its health impact over time and allocate proper resources.

International standardization by including Traditional Medicine within the ICD allows for:

- measuring,
- counting,
- comparing,
- formulating questions and
- monitoring over time.

ICD-11's chapter on Traditional Medicine disorders and patterns is designed to be integrated with coding of cases in conjunction with the Western Medicine concepts of ICD Chapters 1-25.

The TM1 chapter within ICD enables continuity and coordination of care and promotes integrated people centered care for those accessing traditional, complementary and integrative medicine as a means of primary health care. Primary health care is the foundation of integrated service delivery, and the TM1 chapter within ICD-11 allows for coordinating with other levels of services and provides better measurement towards achieving universal health coverage.

3.6 continue

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The chapter will be used in ways appropriate to health care systems, clinical practice and regulations in different countries, but always using standard terminology.

It is important to expose TM practitioners to the rigor of coding and collecting data for reporting and for clinical exchange, as well as for research topics.

Another vital consideration is to allow collection of data relating to patient safety, so that complications and interactions of TM with WM can be monitored.

A standard terminology is also necessary for reimbursement and case mix systems, for education of TM practitioners, for inclusion in electronic record systems and last but not least, for providing currently inaccessible morbidity information to national and international organizations from countries where TM is practiced and is an important part of health service delivery.

As with other ICD chapters, the TM1 chapter is a tool for classifying, diagnosing, counting, communicating and comparing TM conditions, it will also assist research and evaluation to assess the safety and efficacy of TM.

This chapter not judging TM practice or the efficacy of any TM intervention.

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Summary: Importance of ICD-11 Chapter 26 (TM1) for Traditional Medicine Providers in the US

- Establishes Traditional Medicine systems as a legitimate part of Healthcare
- Prompts setting of health policy which recognize Traditional Medicine as diagnosing providers
- Introduces basis for Integration of TM into operational and strategic planning and design of healthcare delivery systems
- Allows for precise measuring the quality, safety and efficacy of care
- Improves tracking of public concerns and assessing risks of adverse public health events
- Advances design of payment systems and processing claims for reimbursement for TM Evaluation and Management codes
- Contributes to preventing and detecting healthcare fraud and abuse
- Facilitates research, epidemiological studies, and clinical trials
- Diversifies clinical, financial, and administrative performance tracking

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Importance of TM terminology standardization for research purposes

Classification of Insomnia Using the Traditional Chinese Medicine System: A Systematic Review

Maggie Man-Ki Poon, Ka-Fai Chung, Wing-Fai Yeung, Verdi Hon-Kin Yau, Shi-Ping Zhang

- A systematic review was conducted to examine traditional Chinese medicine (TCM) patterns commonly diagnosed in subjects with insomnia and clinical features associated with the TCM patterns, and an insomnia symptom checklist for TCM diagnostic purpose was developed based on the review. Two independent researchers searched the China Academic Journals Full-Text Database and 10 English databases.
- A total of 103 studies and 9499 subjects were analyzed. ***There was a wide variation in terminology relating to symptomatology and TCM pattern***. We identified **69 patterns**, with the top 3 patterns (i.e., deficiency of both the heart and spleen, hyperactivity of fire due to yin deficiency, and liver-qi stagnation transforming into fire) and the top 10 patterns covering 51.8% and 77.4% of the 9499 subjects, respectively.
- There were 19 sleep-related, 92 non-sleep-related, 14 tongue, and 7 pulse features included as diagnostic criteria of the top 10 TCM patterns for insomnia. Excessive dreaming, dizziness, red tongue, and fine pulse were the most common sleep-related, non-sleep-related, tongue, and pulse features. Overlapping symptomatology between the TCM patterns was present. A standardized symptom checklist consisted of 92 items, including 13 sleep-related, 61 non-sleep-related, 11 tongue, and 7 pulse items, holds promise as a diagnostic tool and merits further validation.

https://www.hindawi.com/journals/ecam/2012/735078/

Clinical implication of TM terminology standardization

Short-term clinical observation on compound *Xiatianwu* combined with methotrexate in treating rheumatoid arthritis.

Zhao SS[1], Wang J. Dongyang Hospital Affiliated to Wenzhou Medical College, Dongyang 322100, China.

OBJECTIVE: To observe the short-term clinical efficacy of compound Xiatianwu combined with methotrexate (MTX) in treating rheumatoid arthritis.

METHOD: One hundred and four patients with rheumatoid arthritis were randomly divided into two groups: 64 cases in the combined treatment group who was treated with compound Xiatianwu combined with MTX, and the remaining 40 cases in the control group which was only treated with MTX. The changes in ACR20, ACR50, ACR70 and laboratory indexes including anti-cyclic citrulline polypeptide, rheumatoid factor, erythrocyte sedimentation

Treating rheumatoid arthritis patients of Shen deficiency and cold invading syndrome *by bushen quhan zhiwang* decoction combined methotrexate: an evaluation of clinical efficacy and safety.

Wang JM[1], Tao QW, Zhang YZ, Xu Y, Yan XP. TCM Rheumatology, China-Japan Friendship Hospital, Beijing 100029, China.

OBJECTIVE: To evaluate the clinical efficacy and safety of bushen quhan zhiwang decoction (BQZD) combined methotrexate (MTX) in treating rheumatoid arthritis (RA).

METHODS: A prospective, randomized controlled study was carried out. RA patients of **Shen deficiency and cold invading syndrome** in the treatment group (120 cases) were treated with BQZD and MTX (10 mg/week), while those in the

A one-year evaluation of radiographic progression in patients with Rheumatoid Arthritis treated by *Qingre Huoxue Decoction*.

Jiang Q[1], Zhou XY, Wang L, Yu W, Wang P, Cao W, Tang

[1]School of Rehabilitation Medicine, Fujian University of Traditional Chinese Medicine, Fuzhou, 350003, China.

OBJECTIVE: To investigate the effects of Qingre Huoxue Decoction , clearing heat and promoting blood flow; QRHXD), on the radiographic progression in patients with rheumatoid arthritis (RA) by X-ray imaging.

METHODS: Eighty-six patients with active RA diagnosed as **damp-heat and blood stasis syndrome** were randomized into a QRHXD group and a QRHXD plus methotrexate (MTX) group, with 43 cases in

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References

- Research: International Classification of Traditional Medicine
- Implementation of the WHO Traditional Medicine Strategy 2014-2023
- U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?
- Failed Back Surgery Syndrome: A Review Article
- AACM Statistics. Number of People per Active Physician by Specialty, 2017
- National Ambulatory Medical Care Survey: 2016 National Summary Tables
- RESEARCH: The use of complementary and integrative health approaches for chronic musculoskeletal pain in younger US Veterans: An economic evaluation.
- Federal Pain Research Strategy

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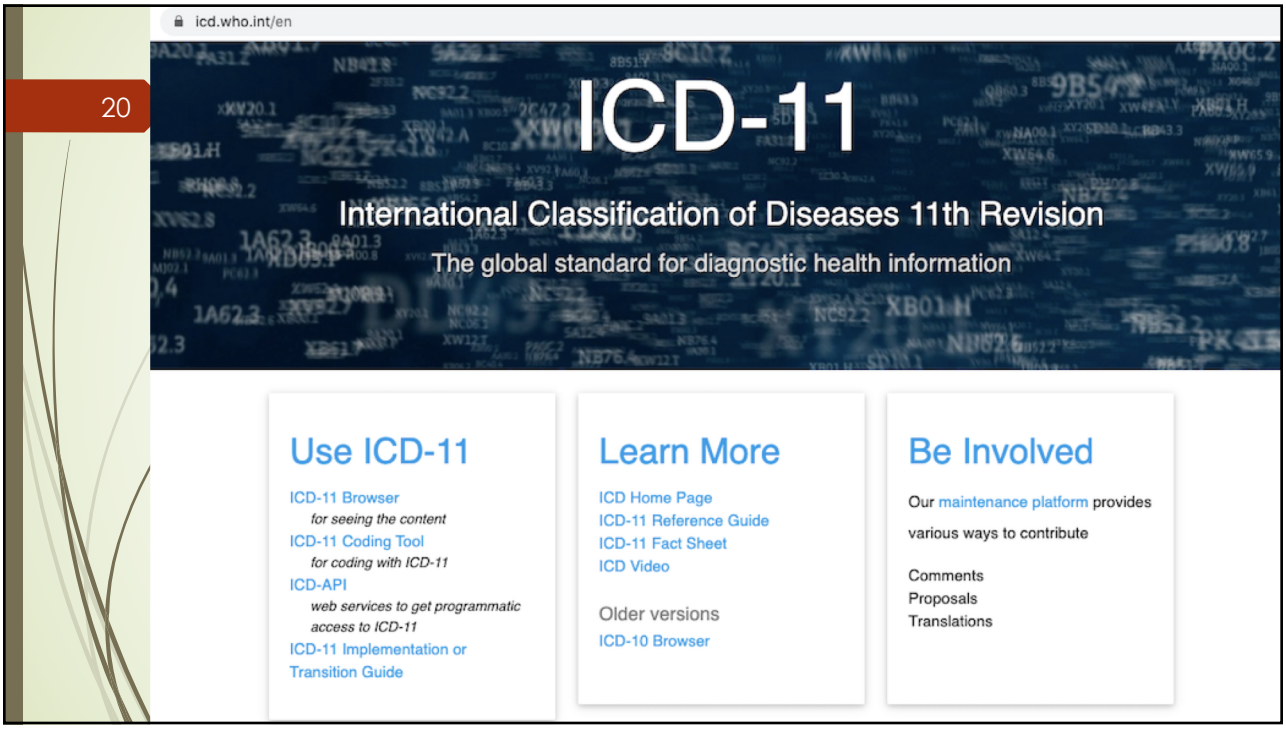

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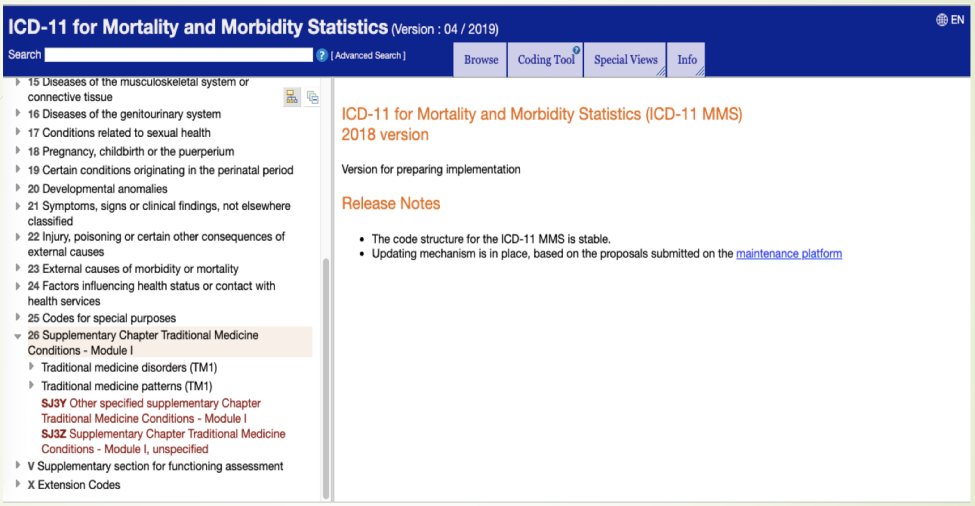
ICD-11 Chapter 26 (TM1)

https://icd.who.int



- Chapter 26 (TM1) is a sub classification for optional use.
- This chapter is not intended for mortality reporting.
- **Coding should always include also a category from the chapters 1-24 of ICD.**

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Chapter 26. Traditional medicine disorders

- Organ system disorders (TM1)
- Other body system disorders (TM1)
- Qi, blood and fluid disorders (TM1)
- Mental and emotional disorders (TM1)
- External contraction disorders (TM1)
- Childhood and adolescence associated disorders (TM1)
- **SE5Y** Other specified traditional medicine disorders (TM1)
- **SE5Z** Traditional medicine disorders (TM1), unspecified

Disorder Definitions:

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A ***disorder*** in traditional medicine, disorder (TM1)[1], refers to a set of dysfunctions in any of the body systems which presents with associated manifestations, i.e. a single or a group of specified signs, symptoms, or findings. Each disorder (TM1) may be defined by its symptomatology, etiology, course and outcome, or treatment response.

- ***Symptomatology***: signs, symptoms or unique findings by traditional medicine diagnostic methods, including inspection such as tongue examination, history taking (inquiry), listening and smelling examination, palpation such as pulse taking, abdominal examination, and other methods.
- ***TM Etiology***: the underlying traditional medicine explanatory style, such as environmental factors (historically known in TM translations as the external contractions), emotional factors (historically known in TM translations as the seven emotions), or other pathological factors, processes, and products.
- ***Course and outcome***: a unique path of development of the disorder (TM1) over time.
- **Treatment response:** known response to traditional medicine interventions. In defining a disorder (TM1), symptomology and etiology are required. Course and outcome, and treatment response are optional.

TM etiology = causative factors

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Internal causes: emotions	External Causes: *climatic factors*	Miscellaneous causes
➢ Anger ➢ Joy ➢ Sadness ➢ Worry/Pensiveness ➢ Fear ➢ Shock	✓ Wind ✓ Cold ✓ Dampness ✓ Dryness ✓ Summer-heat ✓ Fire -heat ✓ *Pestilent factor*	❖ Week constitution ❖ Overwork ❖ Excessive physical activity ❖ Lack of exercise ❖ Excessive sexual activity ❖ Diet ❖ Trauma ❖ Parasites ❖ Poisons ❖ Drugs ❖ Wrong treatment

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Pattern Definitions:

A pattern in traditional medicine, pattern (TM1), refers to the complete clinical presentation of the patient at a given moment in time including all findings. Findings may include symptomology or patient constitution, among other things.

- ***Symptomatology***: signs, symptoms or unique findings by traditional medicine diagnostic methods, including inspection such as tongue examination, history taking (inquiry), listening and smelling examination, palpation such as pulse taking, abdominal examination, and other methods.

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- ***Constitution:*** the characteristics of an individual, including structural and functional characteristics, temperament, ability to adapt to environmental changes, or susceptibility to various health conditions. This is relatively stable, being in part genetically determined while partially acquired.

[1]***'TM1'*** refers to Traditional Medicine conditions - Module I. The (TM1) designation is used throughout this chapter for every traditional medicine diagnostic category in order to be clearly distinguishable from conventional medicine concepts.

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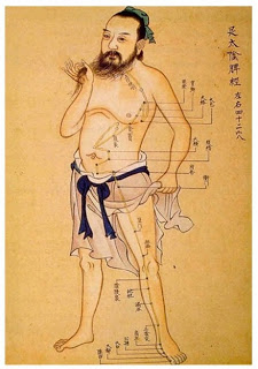
Chapter 26. Traditional medicine patterns

- Principle-based patterns (TM1)
- Environmental factor patterns (TM1)
- Body constituents patterns (TM1)
- Organ system patterns (TM1)
- Meridian and collateral patterns (TM1)
- Six stage patterns (TM1)
- Triple energizer stage patterns (TM1)
- Four phase patterns (TM1)
- Four constitution medicine patterns (TM1)
- **SJ1Y** Other specified traditional medicine patterns (TM1)
- **SJ1Z** Traditional medicine patterns (TM1), unspecified



TM theories to identify patterns

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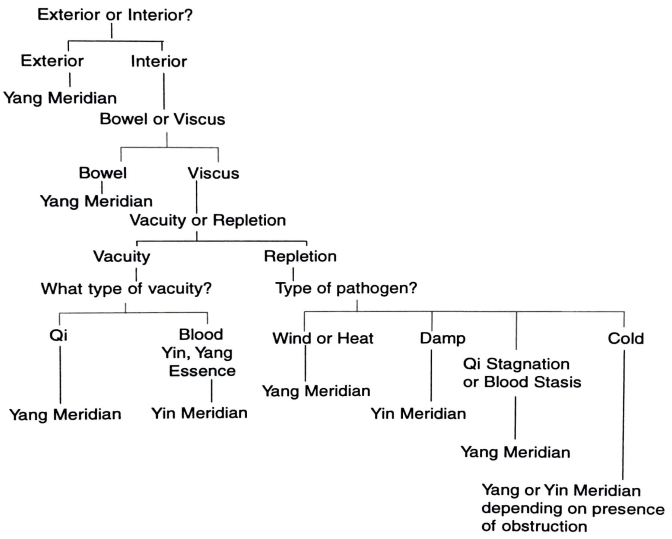
- Eight Principles
- Environmental Factors
- Body Constituents
- Internal Organs
- Meridian
- Pathogen
- 5 element theory
- Biomedicine



J. Pirog. *The Practical Application of Meridian Style Acupuncture 1996*

TM Treatment strategy

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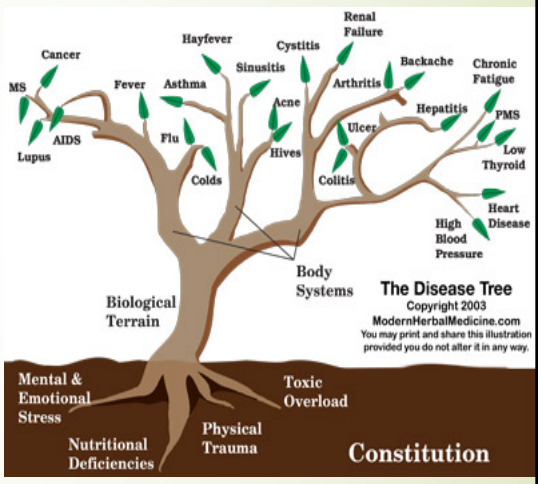
- ***Treat the Root only*** –commonly used if patient presents with multiple vague chronic symptoms/comorbidities.
- ***Threat BOTH Root & Manifestation*** – common if patient presents with distressing manifestation of well defined primary complaint that will not resolve without treating the root.
- ***Treat Manifestation only now & Root later*** – usually used for acute condition than manifestation is severe or life-threatening.



Treatment Principles

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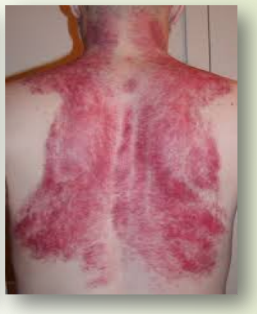
Body Constituents Pattern	ICD11 code	Pattern definition	Treatment principle
Qi patterns			
Qi Deficiency pattern	SE90	A pattern characterized by decreased vitality, fatigue, weakness, appetite loss, short breath, no desire to speak, spontaneous sweating, or feeble pulse. It may be explained by decreased or insufficient quantity of qi.	Tonify Qi Reinforce Qi
Qi Stagnation pattern	SE91	A pattern characterized by a sensation of obstruction in the throat, a sensation of ear tube obstruction, fullness in the chest and hypochondrium or abdominal distension, depressive state or pain. It may be explained by the hindered qi movement.	Move Qi Promote Smooth Flow of Qi Disperse Stagnant Qi
Qi Uprising pattern	SE92	A pattern characterized by coughing, panting, hiccupping, vomiting, and distention of the abdomen. It may be explained by abnormal upward movement of qi.	Direct Qi Downward Descend Rebellious Qi
Qi Sinking pattern	SE93	A pattern characterized by shortness of breath, dizziness, tiredness, downward distension of the abdomen, hypogastria, diarrhea, hemorrhoids, and perineum prolapse. It may be explained by failure of Qi's function to lift or hold.	Raise Qi
Blood patterns			
Blood Deficiency pattern	SF00	A pattern characterized by anemia, atrophic dry skin, alopecia, nail deformity, muscle cramp, forgetfulness, pale or sallow complexion, pale lips, tongue and nails, dizziness, dim vision, palpitation, dreaminess, numbness of hands and feet, and in women, scanty, light-colored menstrual blood, irregular menstruation or amenorrhea, thready pulse, etc.	Nourish Blood Tonify Blood

Traditional Medicine Methods of Treatment

- Acupuncture
- Moxibustion
- Cupping
- Gua Sha
- Massage (Tuina)
- Qigong/Taichi
- Herbs
- Diet



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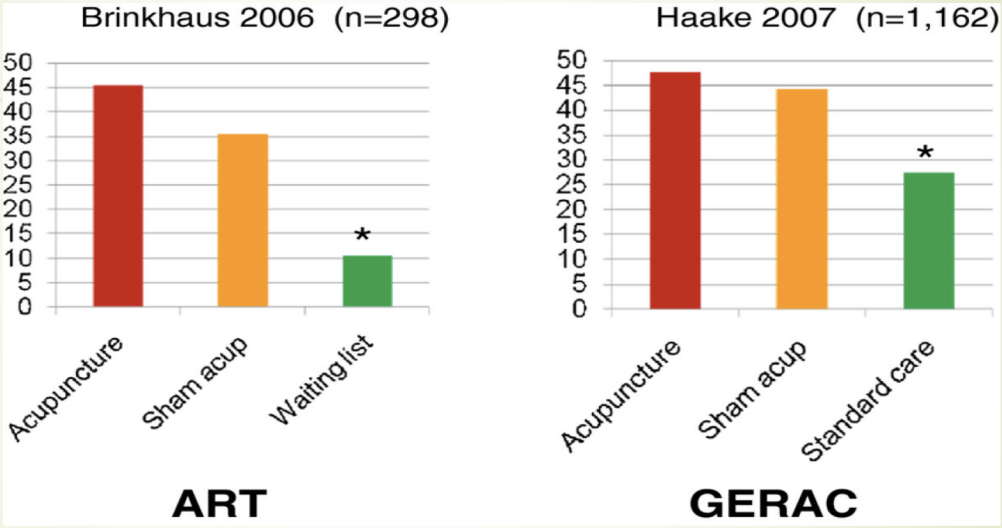
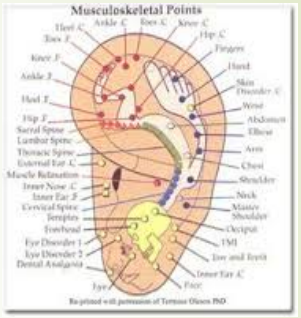
"True" Acupuncture versus "Sham"

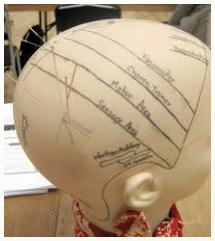


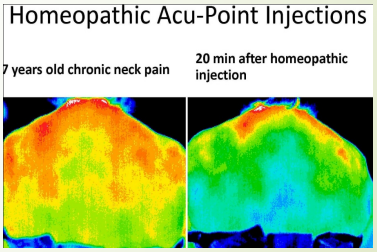
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3996195/

Styles of acupuncture

- TCM
- Japanese
- Korean
- Scalp
- Auricular
- Famous Masters
- Acupoint injections
- Dry Needling







Terminology Case Study #1

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30 years old male presenting with a chief complaint of "pulling" constant low back pain radiating to right buttock that started after camping trip 4 months ago to the lake and is worse with rainy weather. Severity of pain is 4/10. As well has frequent dull frontal headache and sensation of heaviness in the body. Has a frequent loose stool.

- Current **billable ICD10** diagnosis: ***M54.5 Low back pain with right side sciatica***

TCM Style	Japanese – Toyohari style	5 Elements – Worsley Style
Objectively: No pathology was found on X-Ray. Physical Exam: on palpation tender lumbar and gluteal muscles, worse on the right. TCM Tongue: pink, with thicker white coat TCM Pulse: soggy	Observations: Dull, congested, lusterless skin Hara Palpation: damp at HT & SP area Channel Palpation: SP channel sticky and congested Pulses: kyo-jitsu (excess within deficiency); floating; moderate speed	Observation: Yellow, sing, fragrant, sympathy Pulses: SI +1 HT +1 / LU 1- LI 1- GB +1 LR +2 / SP - ST - BL +1 KI +1 / PC +1 TE +1
Non-billable ICD-11 (TM1) pattern: **SE82 Dampness factor pattern (TM1)**	*TM pattern:* **SP sho with LR sokoku**	*TM Pattern*: **Earth CF**
TCM treatment principle: relieve pain, expel wind-damp, move Qi	Treatment Principle: tonify deficiency; disperse excess gently	TP: Assess for Aggressive energy, IDs or EDs; Clear blocks; Tonify CF

ICD-11 Chapter 26 coding challenges

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Basic ICD 11 Coding for Primary and Secondary Sho in Japanese Meridian Therapy as practiced in the Hari Style

Primary Pattern (deficiency in primary channel and mother channel)	Secondary Pattern (Excess or Deficiency or Combination)	Climate	ICD11 Coding Construction for Basic Sho Diagnosis (yang channels handled separately)														Full set of ICD11 Codes to report this Sho (pattern)	General Treatment Principles - *For reference only.* Specification of Tx. Princ Coding can be found throughout regular TCM with ease based on patient presentation.
Lung Sho	Liver Deficient	Cold	Lung Meridian Pattern	SG20	+	Deficiency Pattern	SE75	+	Liver Meridian Pattern	SG2B	+	Deficiency Pattern	SE75	+	Cold Pattern	SE73	SG20, SE75, SG2B, SE75, SE73	Tonify Deficiency, Warm and Move
Lung Sho	Pericardium Excess	Heat	Lung Meridian Pattern	SG20	+	Deficiency Pattern	SE75	+	Pericardium Meridian Pattern	SG2B	+	Excess Pattern	SE74	+	Heat Pattern	SE72	SG20, SE75, SG2B, SE74, SE72	Tonify Deficiency, Disperse Excess, Clear Heat
Lung Sho	Pericardium Deficient	Cold	Lung Meridian Pattern	SG20	+	Deficiency Pattern	SE75	+	Pericardium Meridian Pattern	SG2B	+	Deficiency Pattern	SE75	+	Cold Pattern	SE73	SG20, SE75, SG2B, SE75, SE73	Tonify Deficiency, Warm and Move
Liver Sho	Spleen Excess	Heat	Liver Meridian Pattern	SG2B	+	Deficiency Pattern	SE75	+	Spleen Meridian Pattern	SG23	+	Excess Pattern	SE74	+	Heat Pattern	SE72	SG2B, SE75, SG23, SE74, SE72	Tonify Deficiency, Disperse Excess, Clear Heat
Liver Sho	Spleen Excess	Cold	Liver Meridian Pattern	SG2B	+	Deficiency Pattern	SE75	+	Spleen Meridian Pattern	SG23	+	Excess Pattern	SE74	+	Cold Pattern	SE73	SG2B, SE75, SG23, SE74, SE73	Tonify Deficiency, Disperse Excess, Warm and Move
Liver Sho	Spleen Deficient	Heat	Liver Meridian Pattern	SG2B	+	Deficiency Pattern	SE75	+	Spleen Meridian Pattern	SG23	+	Deficiency Pattern	SE75	+	Heat Pattern	SE72	SG2B, SE75, SG23, SE75, SE72	Tonify Deficiency, clear heat
Liver Sho	Spleen Deficient	Cold	Liver Meridian Pattern	SG2B	+	Deficiency Pattern	SE75	+	Spleen Meridian Pattern	SG23	+	Deficiency Pattern	SE75	+	Cold Pattern	SE73	SG2B, SE75, SG23, SE75, SE73	Tonify Deficiency, Warm and Move
Liver Sho	Lung Excess	Heat	Liver Meridian Pattern	SG2B	+	Deficiency Pattern	SE75	+	Lung Meridian Pattern	SG20	+	Excess Pattern	SE74	+	Heat Pattern	SE72	SG2B, SE75, SG20, SE74, SE72	Tonify Deficiency, Disperse Excess, Clear Heat

Diagnosis formulation rules

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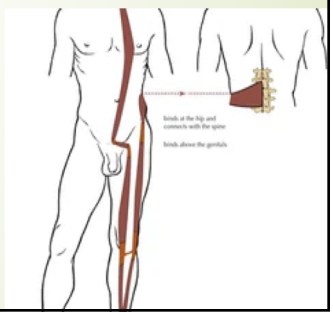
What?		Why?		Where?		
ICD-10 = symptom	➡	Branch pattern	+/-	Root pattern	➡	Meridian affected

Example case study #1

- **Primary billing diagnosis:** ***M54.5 Low back pain with right side sciatica***
- **TM pattern:** ***SE82 Dampness factor pattern (TM1)***
  SF70 Spleen qi deficiency pattern (TM1)
  SG22 Stomach meridian pattern (TM1)



Differences in Treatment Principle formulation based on different styles of Acupuncture

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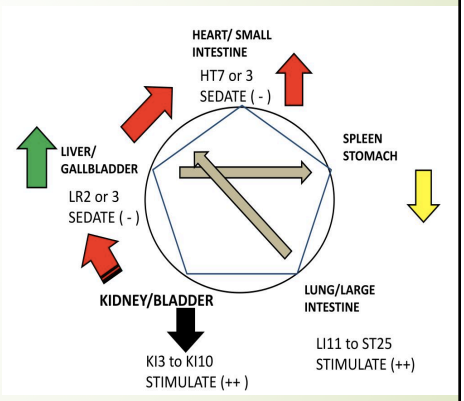
Example case study #1

- **Treatment Strategy is:** Threat BOTH Root & Manifestation

- ✓ **TCM Treatment principle:** relieve pain, dispel wind-dampness, tonify SP Qi, unblock ST meridian
- ✓ **Toyohari Treatment principle:** relieve pain, tonify SP (sho) deficiency, disperse LV (sokoku) excess gently
- ✓ **5 Element - Worsley Treatment principle:** relieve pain; assess for Aggressive energy, IDs or EDs; clear blocks; tonify Earth CF



Recommended reading

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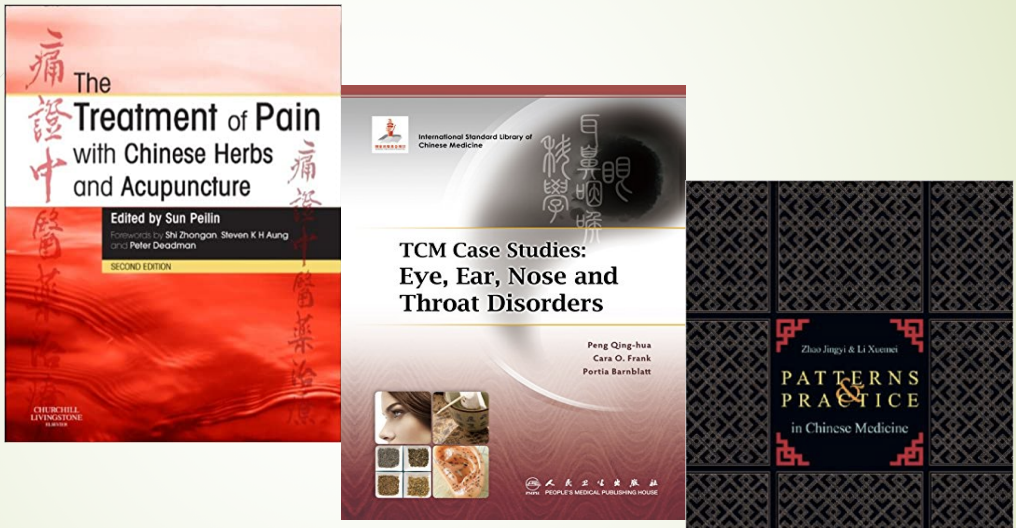
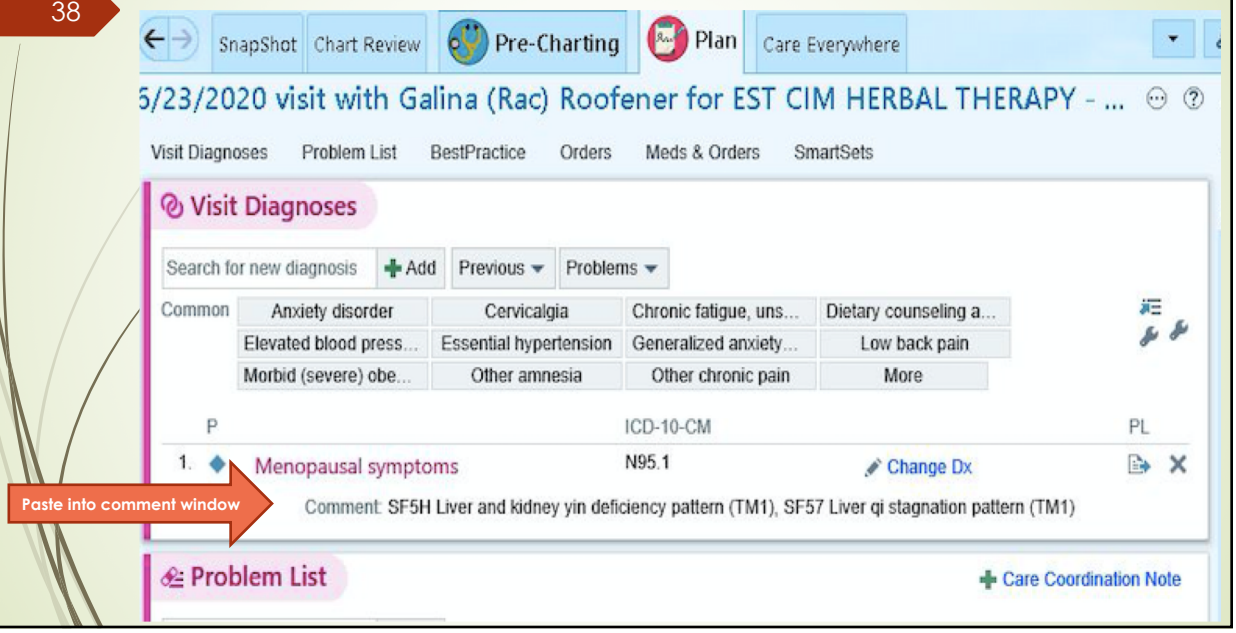


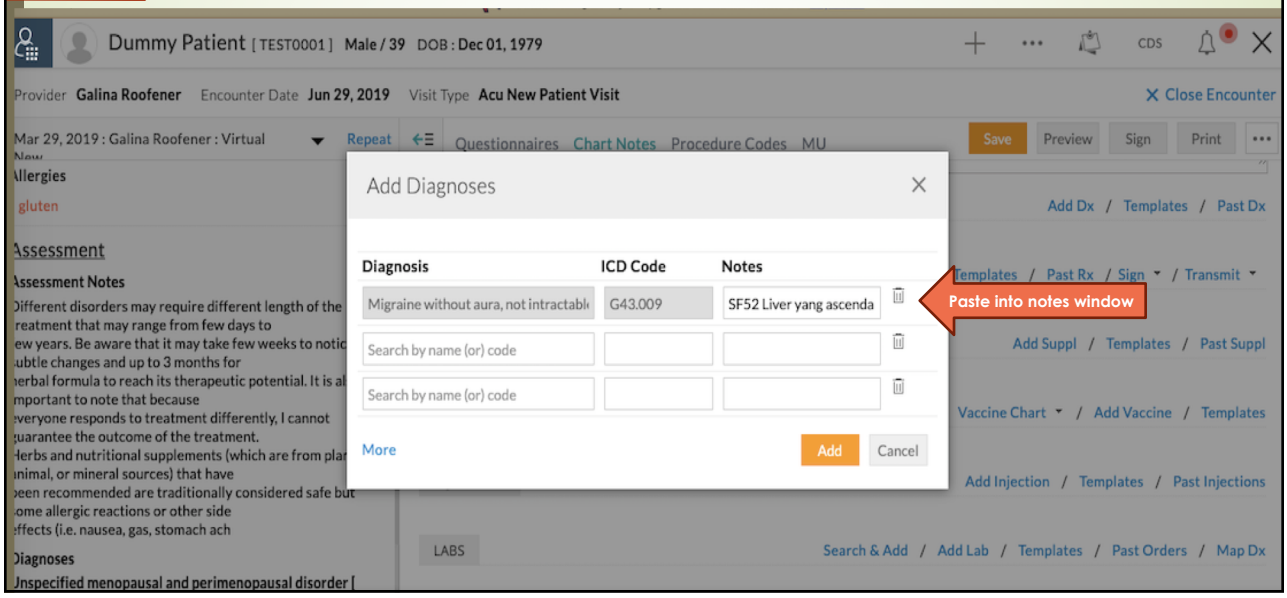
Recording TM pattern in EPIC EHR

38



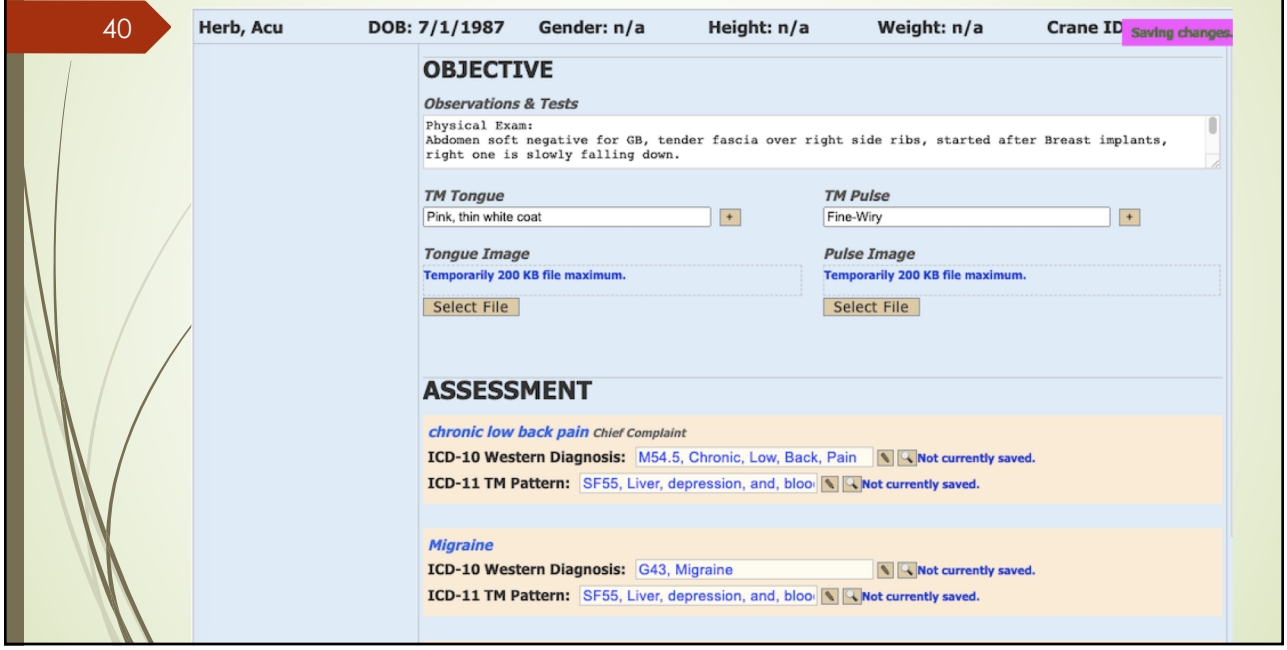
Recording TM pattern in CHARM EHR

39



Recording TM pattern in CRANE Herb EHR

40



ICD-10 Browser

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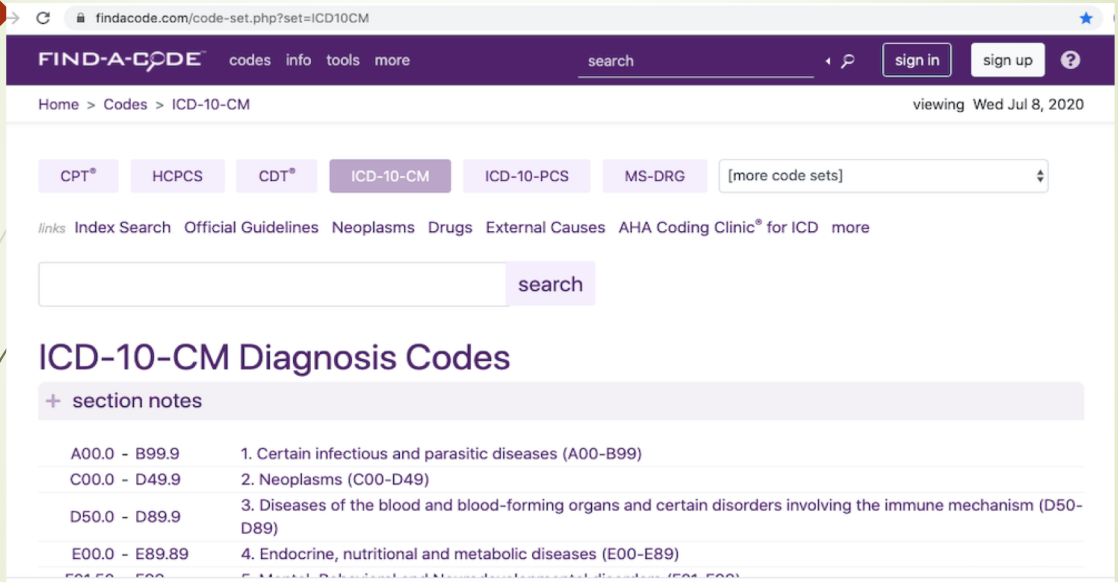

- https://www.findacode.com/search/search.php

WHO ICD-10 browser (2019)

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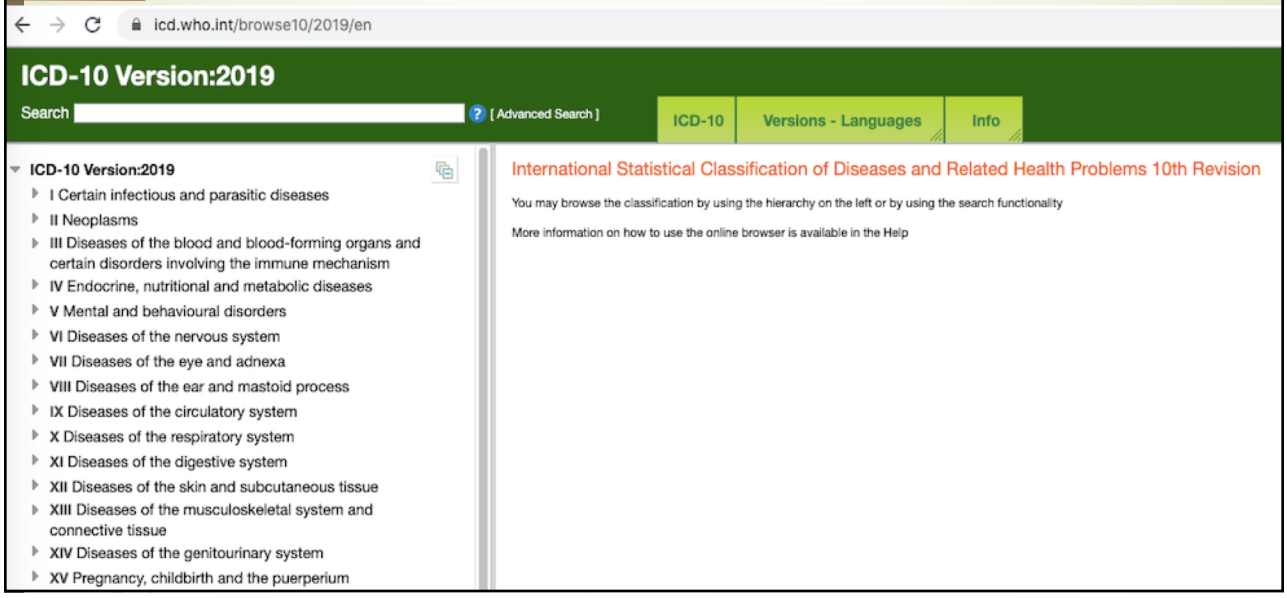

ICD-11 Coding Tool

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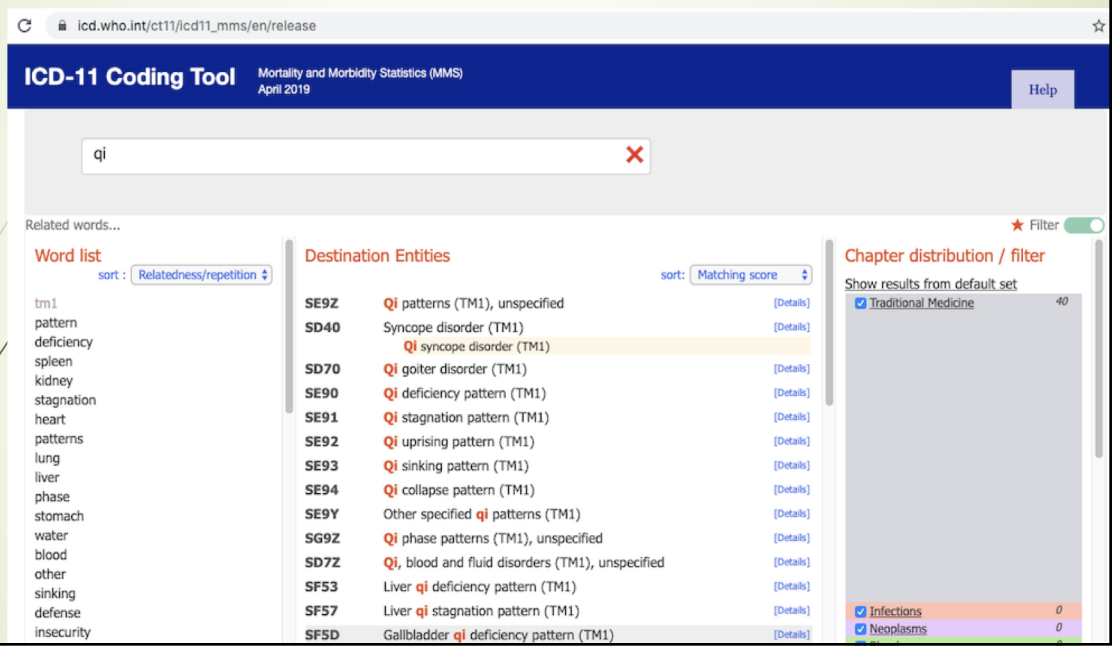

References

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- ASA. Acupuncture effectiveness evidence for pain
- Research: Acupuncture using pattern-identification for the treatment of insomnia disorder: a systematic review and meta-analysis of randomized controlled trials Acupuncture using pattern-identification for the treatment of insomnia disorder: a systematic review and meta-analysis of randomized controlled trials
- Classification of Insomnia Using the Traditional Chinese Medicine System: A Systematic Review
- Inter-Rater Reliability in Traditional Chinese Medicine: Challenging Paradigmatic Assumptions
- Charmhealth EHR
- Unified Practice EHR
- Crane Herb EHR and Compounding TCHM Pharmacy
- Find the code ICD-10 Browser
- WHO ICD-10 browser
- ICD-11 browser
- WHO INTERNATIONAL STANDARD TERMINOLOGIES ON TRADITIONAL MEDICINE IN THE WESTERN PACIFIC REGION Manual
- ICD-11 Patterns description
- ICD-11 Treatment principles

Documentation Requirements

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Medicare - starting year 2021

Medical Records Purpose

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Target Auditory: (this for whom you are writing notes for)

- Lawyer
- Insurance Auditor
- Your colleague for continuation of care
- Patient
- Researcher

Documentation Strategy:

- Accepted format: ***SOAP*** (Subjective, Objective, Assessment, Plan)
- SOAP is your legal defense tool. If you did not wrote it down it did not happened. ***CYA***!
- This is your invoice, each item in it has its cost!
- SOAP does NOT limit what you do, it only outlines the structure HOW you write it down.

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SOAP Content

- **Patient's name, DOB, Treatment date, Type of visit (in-person /virtual)**
- **Current medications: including Rx & OTC; Herbs, Vitamins & Supplements**
- **Known allergies and sensitivities,**
- **Present illness history:** including location, duration, symptoms, affecting factors supporting medical necessity
- **Past health history, Social Determinates of health (social history), Family History**
- **Review of systems**
- **Diagnostic information: physical examinations, vital signs, observation, labs, imaging, tongue, pulse**
- **Medical Decision Making**
- **Biomedical Diagnosis**
- **TM pattern**
- **TM principle.**
- **TM treatment: Acupuncture, Herbs** (Herbal Rx must include: Each Ingredient dosage, lot number, intake dose, how many times a day, etc.)
- **Treatment outcome / prognosis**
- **Treatment goal**
- **Treatment schedule**
- **Home going instruction**

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

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Coding Definition

International Classification of Diseases (ICD)

- Established by World Health Organization (WHO)
- The International Classification of Diseases is a globally used diagnostic tool for epidemiology, health management and clinical purposes.
- https://www.who.int/classifications/icd/factsheet/en/
- https://en.wikipedia.org/wiki/International_Classification_of_Diseases

Current Procedural Terminology (CPT) code

- Established by American Medical Association (AMA)
- Current Procedural Terminology (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT codes are used in conjunction with ICD-10 numerical diagnostic coding during the medical billing process.
- https://www.ama-assn.org/amaone/cpt-current-procedural-terminology
- https://en.wikipedia.org/wiki/Current_Procedural_Terminology

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Bringing it all together: the SOAP note

First, select the appropriate level of E/M services based on the following:

- The level of the medical decision making as defined for each service;

or

- The total time for E/M services performed on the date of the encounter.

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NEW patient determination

- Determination of Patient Status as New or Established Patient Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s).
- A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
- In the instance where a physician/qualified health care professional is on call for or covering for another physician/ qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

ESTABLISHED patient determination

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- An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Problem Definition

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- **Problem**: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
- **Problem addressed**: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service.
- **Referral** without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.
- **Minimal problem**: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211). Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

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History and/or Examination

Office or other outpatient services include a **medically appropriate history and/or physical examination,** when performed.

The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service.

The care team may collect information and the patient or caregiver may supply information directly (eg, by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional.

The extent of history and physical examination is not an element in selection of office or other outpatient services.

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Number and Complexity of Problems Addressed at the Encounter

- One element in the level of code selection for an office or other outpatient service is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may
- Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.
- Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.
- The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Medical Decision Making

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Medical decision making includes:

1. establishing diagnoses,
2. assessing the status of a condition, and/or
3. selecting a management option.

Medical decision making in the office and other outpatient services code set is defined by 3 elements:

1. The number and complexity of problem(s) that are addressed during the encounter.
2. The amount and/or complexity of data to be reviewed and analyzed.
   - Tests, documents, orders, or independent historian(s)*
   - Independent interpretation of tests.
   - Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source.

3. The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.

** (Independent historian(s) (An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.)*

2021 Straightforward & Low level - CPT

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed at the Encounter	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**	N/A	N/A	N/A
99202 **99212** ***NEW 99202: 15-29 min*** ***EST 99212: 10-19 min***	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
 	
NEW 99203: 30-44 minutes
 	
EST99213: 20-29 minutes
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

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2021 **Moderate** level CPT: **NEW-**99204 **EST-**99214

99204 **99214** ***NEW 99204: 45-59 minutes*** ***EST 99214: 30-39 minutes***	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

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Social determinants of health

Medicare Advantage plans in 2019 will be able to provide coverage for a wider variety of non-medical benefits as CMS moves to provide better coverage for **social determinants of health**.

Social determinants of health are the conditions in places where people live, learn, work and play that affect health risks and outcomes. The new definition opens the doors to coverage for new benefits for Medicare Advantage plans, which are projected to cover **22.6 million people** in 2019.

- https://www.cdc.gov/socialdeterminants/
- https://www.pwc.com/us/en/industries/health-industries/health-research-institute/medicare-advantage-coverage-for-social-determinants.html#:~:text=Social%20determinants%20of%20health%20are,22.6%20million%20people%20in%202019.
- https://www.pwc.com/us/en/health-industries/health-research-institute/pdf/CMS-expands-MA-social-determinants_PwC_Jan2019.pdf

A framework of social determinants of health

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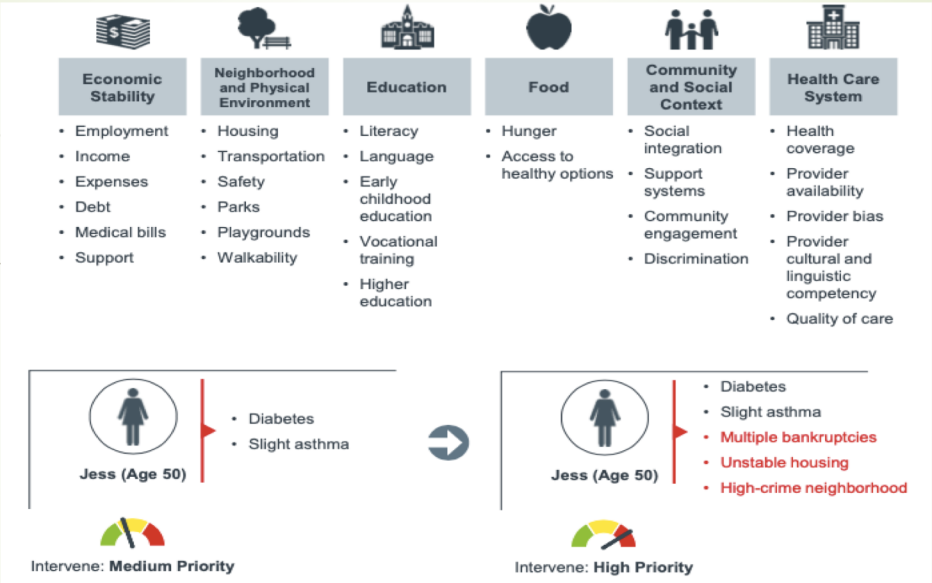

- https://www.advisory.com/-/media/ABI/Research/GEEC/Resources/2018/Global%20eHealth_CheatSheet_SDH.pdf

2021 **High** level CPT: NEW-99205, EST-99215

99205
99215
 	
New - 60-74 minutes
 	
Est - 40-54 minutes
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

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Medical Decision Making Table

To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded **(concept unchanged from current guidelines)**.

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

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Evaluation and Management CPT code based on total TIME

- Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service.
- Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service.
- When time is used to select the appropriate level for E/M services codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional.
- When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and or other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted)

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Time: Office and Other Outpatient E/M Services

2020

- When counseling and/or coordination of care dominates (**over 50%)** the encounter with the patient and/or family, time shall be the key or controlling factor to qualify for a particular level of E/M service
- Only face-to-face time counted

Effective January 1, 2021

- Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service
- Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service

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Total time on the date of the encounter (office or other outpatient services [99202-99205, 99212- 99215]):

It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

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CPT © codes for use by clinicians who HAVE E/M in their scope of practice

- **99421** Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes
- **99422** 11—20 minutes
- **99423** 21 or more minutes

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CPT © codes for clinicians who do NOT have E/M services in their scope of practice

- "For online digital E/M services provided by a qualified non - physician health care professional who may not report the physician or other qualified health care professional E/M services (eg, speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians), see 98970, 98971, 98972)."[2]
- CMS, however, said in the 2020 Final Rule that they would not recognize these codes, because they are defined by CPT has "*evaluation and management*" services, and CMS reserves those words exclusively for **physicians, advance practice nurse practitioners and physician assistants.** These codes have a status indicator of invalid in the Medicare fee schedule, and don't have RVUs assigned to them.
- **98970** Qualified non-physician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- **98971** 11-20 minutes
- **98972** 21 minutes or more

What's Next for E/M Visits: Now and a Look Ahead

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2021 E/M Payment Amounts

		Current (2018) Payment Amount			Revised Payment Amount***		
	Complexity Level under CPT	Visit Code Alone*	Visit Code Alone Payment	Visit Code With Either Primary or specialized care add-on code**	Visit Code with New Extended Services Code (Minutes Required to Bill)	Visit with Both Add-on and Extended Services Code Added**	Current Prolonged Code Added (Minutes Required to Bill)*
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.

**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.

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What's Next for E/M Visits: Now and a Look Ahead

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2017 Medicare Data

- E/M services account for 51% of all PFS spending ($48 billion)
- Office-based E/M services account for 20% of PFS spending ($24 billion)
- Utilization - number of reported services

99201 – 252,423	99211 – 3,884,402
99202 – 2,751,440	99212 – 12,807,980
99203 – 11,410,324	99213 – 98,201,339
99204 – 10,292,014	99214 – 103,181,579
99205 – 2,894,800	99215 – 10,042,159

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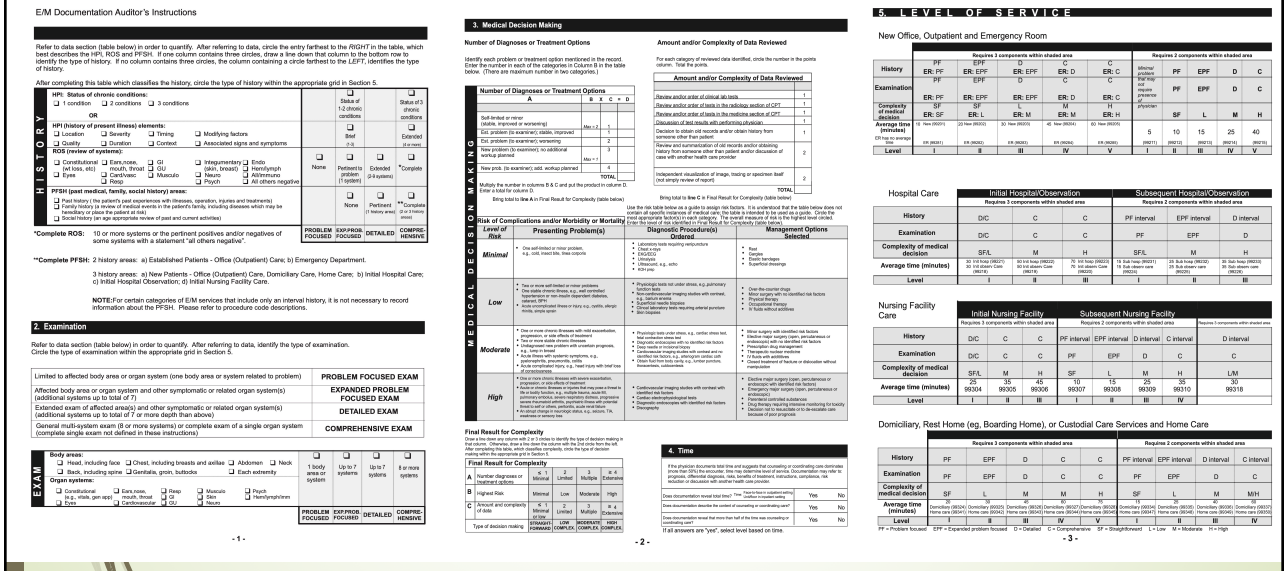
LEAD conference. 01/2019. David Hitzeman, DO, MACOI Chair, AOA Bureau of Socioeconomic Affairs . See full PP handout

Auditor E/M worksheet



E/M Documentation Auditor's Instructions

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the *RIGHT* in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the *LEFT*, identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

HISTORY

HPI: Status of chronic conditions: ☐ 1 condition ☐ 2 conditions ☐ 3 conditions — OR — Status of 1-2 chronic conditions; Status of ≥3 chronic conditions

HPI (history of present illness) elements: ☐ Location ☐ Severity ☐ Timing ☐ Modifying factors ☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms — Brief (1-3); Extended (4 or more)

ROS (review of systems): ☐ Constitutional (wt loss, etc) ☐ Eyes ☐ Ears,nose, mouth, throat ☐ CardVasc ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Integumentary (skin, breast) ☐ Neuro ☐ Psych ☐ Endo ☐ Hem/lymph ☐ All/Immuno ☐ All others negative — None; Pertinent to problem (1 system); Extended (2-9 systems); *Complete

PFSH (past medical, family, social history) areas: ☐ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ☐ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) ☐ Social history (an age appropriate review of past and current activities) — None; Pertinent (1 history area); **Complete (2 or 3 history areas)

PROBLEM FOCUSED	EXP.PROB FOCUSED	DETAILED	COMPRE-HENSIVE

*Complete ROS: 10 or more systems or the pertinent positives and/or negatives of some systems with a statement "all others negative".

**Complete PFSH: 2 history areas: a) Established Patients - Office (Outpatient) Care; b) Emergency Department.

3 history areas: a) New Patients - Office (Outpatient) Care, Domiciliary Care, Home Care; b) Initial Hospital Care; c) Initial Hospital Observation; d) Initial Nursing Facility Care.

NOTE:For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

Limited to affected body area or organ system (one body area or system related to problem)	PROBLEM FOCUSED EXAM
Affected body area or organ system and other symptomatic or related organ system(s)	EXPANDED PROBLEM FOCUSED EXAM
Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)	DETAILED EXAM
General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)	COMPREHENSIVE EXAM

EXAM

Body areas: ☐ Head, including face ☐ Chest, including breasts and axillae ☐ Abdomen ☐ Neck ☐ Back, including spine ☐ Genitalia, groin, buttocks ☐ Each extremity

Organ systems: ☐ Constitutional (e.g., vitals, gen exp) ☐ Eyes ☐ Ears,nose, mouth, throat ☐ CardioVascular ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/imm

1 body area or system	Up to 7 systems	Up to 7 systems	8 or more systems
PROBLEM FOCUSED	EXP.PROB FOCUSED	DETAILED	COMPRE-HENSIVE

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3. Medical Decision Making

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

Number of Diagnoses or Treatment Options A	B	X	C	+	D
Self-limited or minor (stable, improved or worsening)		Max = 2	1		
Est. problem (to examiner); stable, improved			1		
Est. problem (to examiner); worsening			2		
New problem (to examiner); no additional workup planned			3		
New prob. (to examiner); add. workup planned		Max = 7	4		
			TOTAL		

Enter a total for column D.

Bring total to line A in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

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

Bring total to line C in Final Result for Complexity (table below)

MEDICAL DECISION MAKING

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below)

Risk of Complications and/or Morbidity or Mortality Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-ray • EKG/ECG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g.,pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • PT/OT/ST • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV drugs and fluid additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or symptoms of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Final Result for Complexity

Enter a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

Final Result for Complexity				
A Number diagnoses or treatment options	#: 1 Minimal	2 Limited	3 Multiple	#: 4 Extensive
B Highest Risk	Minimal	Low	Moderate	High
C Amount and complexity of data	#: 1 Minimal	2 Limited	3 Multiple	#: 4 Extensive
Type of decision making	STRAIGHT-FORWARD	LOW COMPLEX	MODERATE COMPLEX	HIGH COMPLEX

4. Time

If the physician documents total time and suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Does documentation reveal total time? (Face-to-face in outpatient setting; Unit/floor in inpatient setting)	Yes	No
Does documentation describe the content of counseling or coordinating care?	Yes	No
Does documentation reveal that more than half of the time was counseling or coordinating care?	Yes	No

If all answers are "yes", select level based on time.

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5. LEVEL OF SERVICE

New Office, Outpatient and Emergency Room

	Requires 2 components within shaded area					Requires 2 components within shaded area				
History	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C	Minimal problem focused; may not require presence of physician	PF	EPF	D	C
Examination	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C		PF	EPF	D	C
Complexity of medical decision	SF ER: SF	SF ER: L	L ER: M	M ER: M	H ER: H			SF	L	M	H
Average time (minutes)	10 New (99201)	20 New (99202)	30 New (99203)	40 New (99204)	60 New (99205)		5	10	15	25	40
Of how do average time?	ER (99281)	ER (99282)	ER (99283)	ER (99284)	ER (99285)		(99071)	(99212)	(99213)	(99214)	(99215)
Level	I	II	III	IV	V		I	II	III	IV	V

Hospital Care

	Initial Hospital/Observation Requires 3 components within shaded area			Subsequent Hospital/Observation Requires 2 components within shaded area		
History	D/C	C	C	PF interval	EPF interval	D interval
Examination	D/C	C	C	PF	EPF	D
Complexity of medical decision	SF/L	M	H	SF/L	M	H
Average time (minutes)	30 Init hosp (99221) 30 Init observ Care (99218)	50 Init hosp (99222) 50 Init observ Care (99219)	70 Init hosp (99223) 70 Init observ Care (99220)	15 Sub hosp (99231) 15 Sub observ care (99224)	25 Sub hosp (99232) 25 Sub observ care (99225)	35 Sub hosp (99233) 35 Sub observ care (99226)
Level	I	II	III	I	II	III

Nursing Facility Care

	Initial Nursing Facility Requires 3 components within shaded area			Subsequent Nursing Facility Requires 2 components within shaded area				Requires 3 components within shaded area
History	D/C	C	C	PF interval	EPF interval	D interval	C interval	D interval
Examination	D/C	C	C	PF	EPF	D	C	C
Complexity of medical decision	SF/L	M	H	SF	L	M	H	L/M
Average time (minutes)	25 99304	35 99305	45 99306	10 99307	15 99308	25 99309	35 99310	30 99318
Level	I	II	III	I	II	III	IV	

Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services and Home Care

						Requires 3 components within shaded area				Requires 2 components within shaded area
History	PF	EPF	D	C	C	PF interval	EPF interval	D interval	C interval	
Examination	PF	EPF	D	C	C	PF	EPF	D	C	
Complexity of medical decision	SF	L	M	M	H	SF	L	M	M/H	
Average time (minutes)	Domiciliary (99324) Home care (99341)	Domiciliary (99325) Home care (99342)	Domiciliary (99326) Home care (99343)	Domiciliary (99327) Home care (99344)	Domiciliary (99328) Home care (99345)	Domiciliary (99334) Home care (99347)	Domiciliary (99335) Home care (99348)	Domiciliary (99336) Home care (99349)	Domiciliary (99337) Home care (99350)	
Level	I	II	III	IV	V	I	II	III	IV	

PF = Problem focused EPF = Expanded problem focused D = Detailed C = Comprehensive SF = Straightforward L = Low M = Moderate H = High

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https://www.conventusnj.com/ConventusPortal/media/Member_Resources/Novitas_Solutions_Documentation_Worksheet.pdf

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Scared of Billing ?

OUTSOURCE !

- Acuclaims
- Holistic Billing
- HJRossCompany

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References

- 2020 CMS EVALUATION AND MANAGEMENT SERVICES GUIDE
- 2021 E/M cpt codes -revised-mdm-grid.pdf
- Description of CPT E/M changes, effective January 1, 2021
- E/M Changes in 2021 for 99202-99215 | Overview
- Simple Explanation of E/M 2021 changes with examples
- AMA - E/M CPT change updates
- Medicare Physician Fee Schedule Rule
- What's Next for E/M Visits: Now and a Look Ahead
- Social Determinants of Health: Know What Affects Health
- The Accountable Health Communities Health-Related Social Needs Screening Tool
- CMS expands Medicare Advantage coverage for social determinants of health
- AMERICAN ACADEMY OF MEDICAL ACUPUNCTURE 2011 CODING REFERENCE SHEET
- Auditor E/M score worksheet

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References

- VA pain assessment scale
- VA/DoD Clinical Practice Guidelines
- VA/DoD CLINICAL PRACTICE GUIDELINE FOR DIAGNOSIS AND TREATMENT OF LOW BACK PAIN
- Pain Awareness Toolkits

Reproducible data, Standards of practice?

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Herb, Acu DOB: 7/1/1987 Gender: n/a Height: n/a Weight: n/a Crane ID: 691330

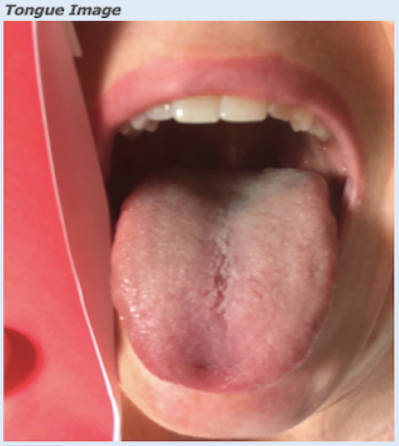
TM Tongue

Pink
Coating-Thin-White
reddish tip*

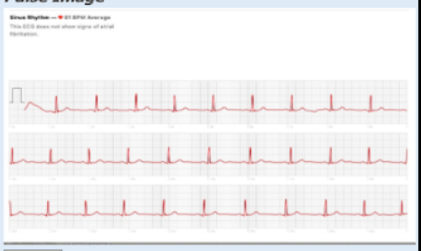
TM Pulse

slow *
Wiry
Unrooted
regular*

Tongue Image



Pulse Image



Delete

Where East meets West Measurable Outcomes

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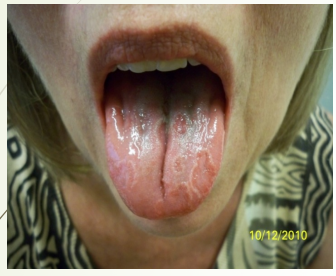

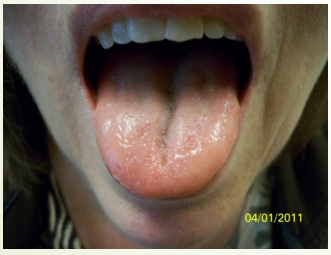

Saliva Test		Range	Reference
Cortisol	morning	0.2 L	3.7-9.5 ng/ml
Cortisol	noon	0.3 L	1.2-3.0 ng/ml
Cortisol	evening	0.4 L	0.6-1.9 ng/ml
Cortisol	night	0.2 L	0.4-1.0 ng/ml

Saliva Test		Range	Reference
Cortisol	morning	4.2	3.7-9.5 ng/ml
Cortisol	noon	2.0	1.2-3.0 ng/ml
Cortisol	evening	0.9	0.6-1.9 ng/ml
Cortisol	night	1.1 H	0.4-1.0 ng/ml

Medical Decision Making (MDM)

- Medical decision making grid, which weighs the type of decision making with:
- 1) Number and complexity of problems;
- 2) Amount and/or complexity of data and
- 3) Risk

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
minimal	minimal or none	minimal	straightforward
limited	limited	low	low complexity
multiple	moderate	moderate	moderate complexity
extensive	extensive	high	high complexity

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SOAP templates and examples

Acupuncture

- SOAP - Acupuncture Initial Appointment Template
- SOAP Straightforward level - Acupuncture Initial Encounter - Example
- SOAP Low Level - Acupuncture Initial Encounter - Example
- SOAP Moderate level - Acupuncture Encounter - Example
- SOAP - NO E/M Follow Up Acupuncture Template
- SOAP - No E/M Follow Up Acu Encounter Example
- SOAP - Acupuncture + E/M Follow Up Template
- SOAP - Straightforward level - Acupuncture Follow Up Example
- SOAP - Low level - Acupuncture Follow Up Example
- SOAP - Moderate - Acupuncture Follow Up Example

Herbal

- SOAP - Herbal Initial Encounter Template
- SOAP - Herbal Initial Encounter Example
- SOAP - Herbal Follow Up Template
- SOAP - Herbal Follow Up Example

are YOU ready ?!?

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Special thank you to my consultants

Gretchen Gonzalez

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David Tucker

Bill Egloff