

# Best Practices in Documenting and Coding High-Value Care in Workers' Compensation Encounters—ACOEM Guidance Statement

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**Abstract:** Workers' compensation outpatient care requires attention to causation, functional assessment, work disability prevention, and return-to-work planning, elements not usually addressed in other types of outpatient encounters. Because these elements of care deviate from the usual pattern of ambulatory services, providers of workers' compensation care have faced challenges in billing and auditing practices resulting in underpayment when providing high-value care based on evidence-based guidelines. Recent changes in Centers for Medicare & Medicaid Services rules on documentation requirements for coding outpatient evaluation and management encounters offer an opportunity for occupational health clinicians to be paid appropriately for care that follows occupational medicine practice guidelines. There remains a need to define the elements of documentation that should be expected in delivering high-value workers' compensation care. This article provides guidance for documenting high-value workers' compensation care.

**Keywords:** workers' compensation, encounters, coding, documentation, medical decision-making, value, work disability

There has been increased recognition in recent decades of the need to promote "high-value" care, which aims to improve health, avoid harms, and eliminate wasteful practices.<sup>1</sup> Medical educators have recognized that the way to achieve this is to focus on professionalism, by teaching physicians to support the primacy of the patient's well-

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## LEARNING OUTCOMES

1. Identify important medical history elements needed in workers' compensation encounters that are not considered in the group health evaluation and management encounter paradigm.
2. Understand factors that complicate outcomes in workers' compensation claims compared with ambulatory care provided in other clinical contexts.
3. Determine the optimal coding rules (based on time or medical decision-making) to apply in clinical encounters, with attention to high-value documentation needed by stakeholders as well as fair reimbursement.
4. Evaluate personal opportunities to improve workers' compensation clinical documentation, to support high-value care and appropriate reimbursement.

fare by recognizing both physical and financial patient harm and by honoring the core responsibility of physicians and other clinicians to be good stewards of precious resources.<sup>2</sup> Initiatives like the Choosing Wisely campaign have recruited medical specialty organizations to help identify examples of low-value care (the use of unnecessary and potentially harmful health care services).<sup>3</sup> The American College of Occupational and Environmental Medicine (ACOEM) has produced multiple guidance documents and practice guidelines to help physicians caring for patients with work injuries provide high-value care.<sup>4-6</sup>

However, most workers with injuries or illnesses related to work are treated by physicians or other clinicians who are not ACOEM members and who may not be familiar with the nuances of care that make workers' compensation (WC) encounters different from their usual outpatient encounters.<sup>7-10</sup> For most of these clinicians, WC is not a focus of their practice, and there is limited understanding of the elements of care that are critical for good outcomes, including preventing avoidable work disability.<sup>11</sup> These elements include:

- Familiarity with WC statutes and systems,
- Assessment of causation,
- Impact of the condition on function,
- Risk factors for work disability,
- Work status and barriers to returning to regular work duties, and
- Determination of medical end point and impairment (when applicable).

Documentation of these elements is important for appropriate management of the case, both by the medical system and by other stakeholders, as shown by research in Washington<sup>10</sup> and Colorado,<sup>12</sup> states that have adopted interventions to improve WC documentation and have seen improved outcomes. This article provides a primer for considering these elements and documenting these elements in the medical record, while considering recent changes in rules related to coding outpatient encounters that provide a mechanism for ensuring appropriate reimbursement for high-value care in WC.<sup>4</sup>

The purpose of this article is to describe:

- The reasons for the worse outcomes in WC cases compared with care for the same conditions outside WC systems;
- Approaches to mitigate the worse outcomes in WC claims;
- The increased burden of evaluation and treatment in WC claims compared with other types of outpatient encounters; and
- How addressing deficiencies in documenting care and related coding for reimbursement will improve outcomes in the care of WC claimants.

## Workers' Compensation Outcomes

Much research has demonstrated that clinical outcomes in WC are worse than they are for the same conditions treated under other systems.<sup>13-15</sup> A meta-analysis on the effect of compensation status on outcomes following upper extremity surgery, which included studies from several countries, concluded that patients not receiving WC were three times more likely to experience improvement after surgery than patients receiving WC benefits.<sup>16</sup> Similarly, a systematic review and meta-analysis on spinal surgery outcomes found that WC

patients had higher postoperative pain and disability, lower satisfaction after surgery, and delayed return to work compared with patients receiving the same care outside of the WC system.<sup>17</sup>

The reasons for worse outcomes in WC claimants are multifactorial and include delays in authorization,<sup>18</sup> attorney involvement,<sup>19</sup> the need for attorney involvement,<sup>20</sup> early prescriptions for opioids,<sup>21</sup> socioeconomic differences in those treated under WC,<sup>22</sup> external fault attribution,<sup>23</sup> patient factors such as pain catastrophizing and fear/avoidance,<sup>24–26</sup> and patient experience of work factors.<sup>25,27,28</sup> These risks have been categorized using the familiar flag system, with yellow flags representing the patient's beliefs, behaviors, and emotional responses; blue representing the patient's work experience; orange representing the patient's history of mental illness; and black representing legal and system obstacles (Fig. 1).<sup>24</sup> Less well studied are potential differences in outcomes based on race or ethnicity, with one systematic review finding worse return-to-work outcomes for non-White and racial/ethnic minority workers for nonoccupational disabling conditions, but with insufficient research on such disparities in WC conditions.<sup>29</sup> Understanding the reasons for this gap between outcomes in group health and WC will point us to opportunities to apply prevention principles to patients treated for work injuries. Although not all these risk factors are under the control of the treating clinician, there is an opportunity to mitigate many of these risk factors for poor outcomes by assessing and documenting the critical elements particular to WC care.

### Preventing Poor Outcomes in WC

There is myriad evidence that work disability is an important risk factor for poor health. Early return to work improves health outcomes, whereas work disability threatens health.<sup>30–32</sup> Much work disability in WC is preventable, that is, not correlated with medical necessity, but attributable to psychosocial factors such as those illustrated in Figure 1.<sup>33</sup>

The Disability Prevention and Return to Work Committee of the International Association of Industrial Accident Boards and Commissions (IAIABC) published “A How-To Guide for Injury and Work Disability Prevention.”<sup>34</sup> IAIABC is the largest trade association of WC jurisdictional agencies in North America, collaborating with private organizations involved in the delivery of WC coverage, benefits, and services to empower, educate, and connect the global WC community to reduce harm and aid recovery from work injuries and illnesses.<sup>35</sup> This committee noted in this guidance document that there are four principles of preventing the development of unnecessary work disability:

1. Preventing unnecessary delays.
2. Preventing unnecessary duration.
3. Preventing a confusing process.
4. Preventing unclear return to work plans.

Unnecessary delays in treatment are largely attributable to delays in authorization, which are a predictable outcome when work causation or relation of the requested treatment to work injury is not clear to the WC insurer.

Attention to documenting this information in the medical record can mitigate this problem. Unnecessary duration relates to prolonged work disability, with contributions from the above-cited psychosocial risk factors, when not identified and managed. A confusing process is the norm for the injured worker and often the physicians if WC is not a regular part of their practice. Mitigation involves learning enough about the WC system to appropriately advise the patient, request treatment, and manage expectations of the worker, employer, and insurer. Medical documentation that does not address return-to-work planning, or does not provide support for the documented plan, may contribute to the overall worse outcomes in WC care. It is important to note that although there is research on the value of treating physician return-to-work communication (verbal and via state-system forms),

we were unable to identify any research that specifically addressed the content of the medical note in WC outcomes.<sup>10,36</sup>

In the IAIABC document, the importance of medical documentation in preventing unnecessary work disability is evident:

“1. Examination, diagnosis, and treatment thoroughly documented in the medical record. The record must include return-to-work goals and a method for objectively evaluating functional improvement. Consider whether there is a specific reason that poses a risk of harm or is unsafe for the injured worker patient to remain in or return to the workplace.

2. Communication and education is another element of the provider's activities. This includes not only education and shared decision-making with the patient, but also working with the employer and other caregivers such as physical therapists, rehabilitation centers, and vocational providers.

3. Documentation is an essential portion of the medical provider's role so that personnel involved in the patient's care and return to work can clearly understand the provider's work restrictions and functional goals.”<sup>34</sup>

### Applying the Principles of Prevention to WC Care

Most clinical practitioners appreciate the concepts of primary, secondary, and tertiary prevention as applied to screening for and treatment of chronic medical conditions. In primary prevention, measures are taken to prevent the medical condition of interest, for example, recommending seatbelts to prevent motor-vehicle trauma or providing vaccinations to prevent an infectious disease. In secondary prevention, we screen for the presence of an asymptomatic condition or risk factor, so that treatment can be provided to prevent symptomatic illness. Examples are hypertension, cancer, or hyperlipidemia screening. In tertiary prevention, illness is present, and we take measures to prevent complications and improve quality of life. A less familiar concept is “quaternary prevention,”<sup>37,38</sup> in which the patient has symptoms that may not represent illness needing treatment—in quaternary prevention, we avoid unnecessary and sometimes harmful excessive medical care. Quaternary prevention is defined as “action taken to identify patient at risk of overmedicalization, to protect him from new medical invasion, and to suggest to him interventions, which are ethically acceptable.”<sup>39</sup> Another way to think of it is: “action taken to protect individuals (persons/patients) from medical interventions that are likely to cause more harm than good.”<sup>37</sup> An example would be avoiding low-value care such as lumbar imaging early in a case of nonspecific low back pain without clinical red flags.<sup>40</sup>

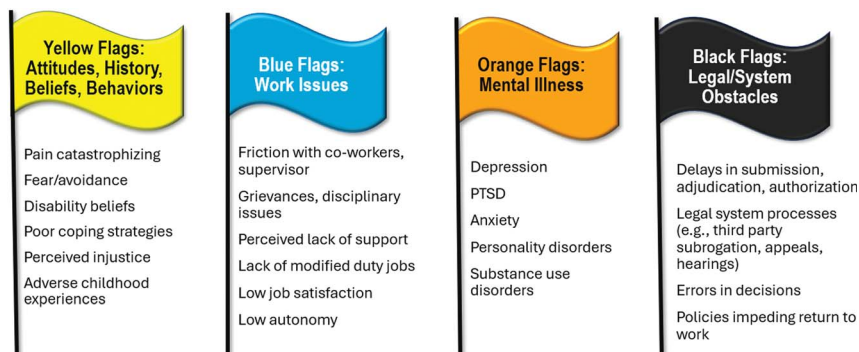


FIGURE 1. Flag system for work disability risk.

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Similar concepts can be applied to WC care. The treating physician or other clinician in WC may participate in primary prevention of work injuries by determining causation, identifying unsafe work conditions that need to be corrected to prevent the next injury, such as ergonomic modifications and hazard mitigation. Although primary prevention of work injuries and illnesses provides the most important opportunity to reduce the cost of WC, there are additional opportunities to reduce costs by using the principles of secondary, tertiary, and quaternary prevention in WC treatment.<sup>37</sup> Secondary prevention, as applied in WC care, refers to identifying risk for work disability and managing it expectantly. For example, patients who think about their pain in catastrophizing ways may fear movement, which is important to recovery.<sup>25,28,41,42</sup> Identifying such risk and referring such patients to a physical therapist knowledgeable about behavioral approaches for an early supervised exercise program are an example of an effective secondary prevention measure.<sup>4</sup> Tertiary prevention applies when treatment is optimized to prevent complications, reduce risk, and improve outcomes. In WC care, tertiary prevention is applied by following evidence-based guidelines in treatment.<sup>6</sup> Quaternary prevention in WC care means providing high-value care that meets the needs of the patient without overmedicalizing the situation or providing potentially harmful care.<sup>6</sup> Examples include avoiding unnecessary diagnostic testing, avoiding opioid analgesics for minor musculoskeletal injuries, and applying appropriate activity restrictions if activity restrictions are advisable at all. All these levels of prevention can and should be addressed in medical documentation during WC encounters.

Each of the above preventive measures will help close the gap between the poor outcomes seen in WC and those seen in other medical treatment contexts. The treating clinician has a role to play in each of these four measures, with clinical documentation playing a large role. Clinicians can help prevent unnecessary delays by clearly documenting causation rationale (which helps determine WC system coverage), as well as rationale for needed treatment if outside the usual “treatment suites” that specify expected care for specific conditions. Treating practitioners can help prevent unnecessary duration of claims by avoiding medically unnecessary off-work recommendations and by clearly documenting their assessment of work capacity, treatment plans, and prognosis. The best way for a treating clinician to reduce process confusion for the patient is to learn enough about the process to help patients navigate the system. Physicians and other clinicians should address return-to-work planning at every visit and establish expectations of returning to work with the patient, collaborating with other stakeholders in the system.

### The Connection Between WC Outcomes and Medical Documentation

Injured workers require medical care and careful attention to factors that will help them recover their ability to participate fully in society, including work, but most current standard medical practice guidelines focus on diagnosis and treatment of symptoms, not function. At present, there is no widely used system of documentation or coding guidance for WC clinical encounters that is specifically geared toward maximizing outcomes for both patient health and patient work function. Clinical encounters for WC system purposes differ in many ways from evaluation and management encounters for personal medical care. Yet, the documentation and coding norms are usually the same. This leads to a disconnect between the information needed by stakeholders in the WC system and the documentation required for billing specific levels of care. It also contributes to unfair compensation, with no systematized mechanism for incentivizing the delivery of services by clinicians who document and address issues important in WC but outside the norms established by Medicare/Medicaid and group health medical insurance systems.<sup>4</sup> The resulting misalignment between coding rules designed for other purposes and WC best practices has often negatively impacted medical outcomes for injured workers and created barriers to improved health care quality and needlessly increased medical and disability costs.<sup>4</sup>

In 2013, the ACOEM established, at the request of its members, a task force to address these gaps between the documentation required to be paid for care and what needs to be documented if following evidence-based best practices in WC. The ACOEM Task Force on Coding Quality Care in WC was asked to make recommendations about how to close this gap so that treating clinicians would be appropriately reimbursed for providing high-value care that improves out-

comes in injured workers. The Task Force published a paper with its recommendations for defining documentation requirements for coding quality care in WC in 2016 as an ACOEM Guidance Statement.<sup>4</sup>

The Task Force members recognized that the recommended model for documenting and coding value-based services in WC would be difficult to adopt in a healthcare setting based on the then-current rules established by the Centers for Medicare & Medicaid Services (CMS) documentation requirements for using the Current Procedural Terminology (CPT®) (hereafter referred to as the CMS/CPT® model) evaluation and management (E&M) codes.<sup>43</sup> These documentation rules are firmly entrenched in electronic medical record systems as well as the systems for billing and auditing services, and WC payers align their coding and documentation requirements (although not necessarily the fees) with the prevailing CMS/CPT® model (Fig. 2). With a highly automated medical system, the Task Force determined that the optimal approach would be to build a set of ground rules for WC encounters that aligned with the CMS/CPT® model but included elements needed by WC system stakeholders. The proposed approach would provide guidance for documenting many of the services relevant in WC encounters to align them with a function-based evaluation. Figure 3 depicts the proposed change in emphasis in the medical documentation sections of an E&M encounter from a symptom-oriented model to a function-oriented model.

### 2021 E&M Encounter Coding Rules Present an Opportunity

In response to requests from physicians in a wide range of specialties and clinical care settings, in 2021, CMS established new rules for coding outpatient E&M encounters. Clinicians are now allowed to use either time-based or medical decision-making (MDM)-based codes.<sup>43,44</sup> The 2021 rules apply to CMS-funded care but have been adopted by most,

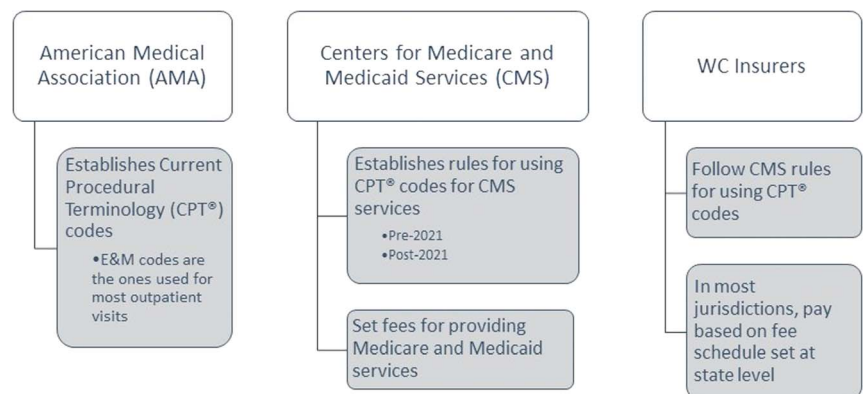


FIGURE 2. Relationship among codes, rules and fees.

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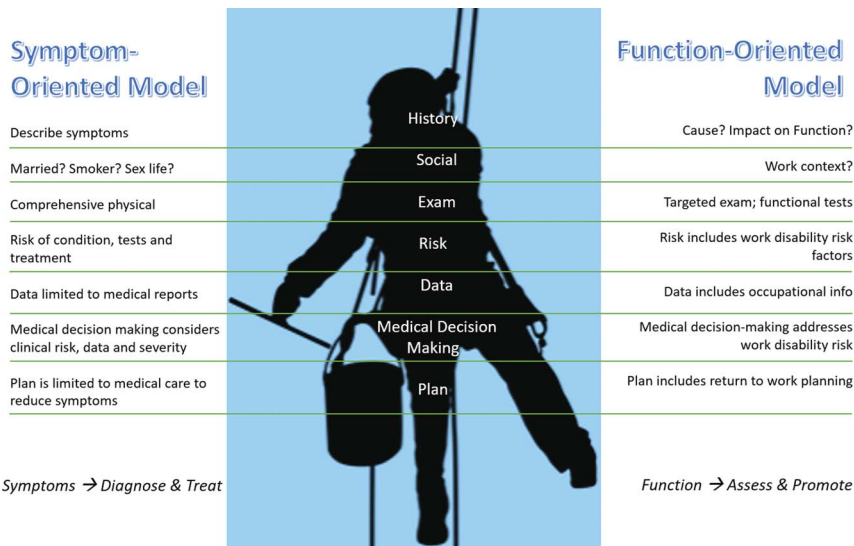


FIGURE 3. Symptom- versus function-oriented documentation model.

if not all, health insurance plans and WC insurance payers.

The 2021 E&M rules are summarized here:

- Time-based coding is permitted when the documentation supports that over half the encounter was spent on counseling or care coordination activities. There is no need to document specific elements of history, examination, or basis for MDM. The documentation must include the amount of time spent and what it was spent on. Total time includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional (as defined by the relevant jurisdiction) on the encounter date. Clinical staff time is not counted.
- MDM-based coding may be used as an alternative to time-based coding, but the selected code must meet the criteria for number and complexity of patient problems, amount of data reviewed, and level of risk. ACOEM has proposed additional types of data and risk considerations to be included in MDM involving WC care in a tip sheet for practices.<sup>45</sup>
- There are now four instead of five levels of care involving the treating practitioner: straightforward, low, moderate, and high MDM levels.

Note that many WC jurisdictions permit use of codes that are no longer reimbursed by CMS; research on permitted codes in a given WC jurisdiction should include options for billing for extra time and telehealth services. The codes 99358 and 99359 are permitted in many WC jurisdictions to document and bill for time spent reviewing infor-

mation related to an encounter; these may not be billed on the same day of service as the encounter.<sup>43,46</sup> Although not used by CMS, some WC jurisdictions permit using 99417, for prolonged office or other E&M service beyond 99205/99215 with or without direct patient contact; this code may only be used on the same date of service as the encounter when using time-based coding, in 15-minute increments.<sup>43,45</sup> Using such codes when permitted can be helpful in capturing and seeking reimbursement for time spent outside of an encounter on work investigating the circumstances surrounding a specific WC injury or illness. Also, some WC jurisdictions permit use of codes 99441 to 99443 for telehealth services.<sup>43</sup>

The 2021 CMS rules decrease the burdensome requirements to document many of the previously required elements of history or examination that are irrelevant to a given encounter. This should be helpful to providers of WC care. However, the 2021 CMS rules do not provide incentive for high-value care attentive to the special needs of a WC encounter, including evaluating and describing causation, assessing functional impact and promoting functional recovery, assessing work disability risk and barriers to returning to work, monitoring work status, and managing return-to-work planning. Research studies describing the impact of WC program innovations in several states (Washington, Ohio, and Colorado) have demonstrated the value of establishing expectations for documenting the issues needed for optimal outcomes in WC. The approaches used in these states rely on their monopolistic systems (Ohio and Washington) or biopsychosocial coverage laws (Colorado).<sup>9,10,12,47</sup> The most well-studied of these systems is the Washington state system, which provides additional payments to treating clinicians for documenting

needed information. In Washington, treating physicians complete a form that requests information about the critical details addressed in this paper and are reimbursed for the time to complete and submit this information.<sup>48</sup>

The following recommendations are designed to assist WC commissions, insurance carriers, treating clinicians, and other interested parties to establish requirements and practices for documenting services in WC encounters and to develop incentives for providing high-value care.

### Recommended Model for WC Evaluation and Management Encounter

Medical care should be focused on more than symptom reduction—ideally, medical encounters (even those not related to WC) should support the restoration of normal life activities, including work.<sup>49</sup> Attending to function as a vital sign would increase the value of medical care in every clinical setting and is critical to clinical encounters related to WC injuries, as recommended by an expert panel representing multiple different specialties in a guidance document published in 2020.<sup>50</sup>

Refer to the call-out box for a synopsis of ACOEM's recommended documentation elements in WC encounters, to be included whether using time-based or MDM-based coding. Attention to these elements will provide an appropriate and auditable alignment of reimbursement with documentation of necessary elements of history, examination, MDM, and problem severity. Our proposed model offers examples of counseling and care coordination activities that are appropriate and valuable in WC care.

### DOCUMENTATION OF THE HISTORY

#### The Initial Encounter

The initial encounter is the best time to obtain a detailed historical timeline that can be verified and will help establish work-relatedness and causation. Particular attention should be paid to the mechanism of injury, work factors/contribution (ie, job description), and use of protective equipment. See Table 1 for examples of types of work causation, which may vary by jurisdiction. There must be careful documentation of frequency, intensity, duration, and temporal patterns of symptoms and exposures.<sup>52</sup> The history should also explore and document the impact of the condition on the patient's function, including in relation to usual work activities.<sup>50</sup>

#### Subsequent Encounters

Subsequent encounters for managing a WC claim following a detailed initial encounter should document interim clinical

**Critical Elements to Document in WC Encounters**

**Causation:** Document the mechanism of injury, causation rationale, and relationship of work factors to the presenting condition, as applicable. Attention to causation rationale from the beginning will provide information needed for claims adjudication and treatment authorization, thus decreasing the risk of unnecessary and frustrating delays in care.

**Function:** Assess and document functional impact of the condition and implications for work in both the history and the examination. Continue to monitor functional outcomes in subsequent visits. Note that when the encounter includes recommendations about dealing with the functional impact of a condition and improving function, this should be documented as counseling provided when using time-based coding.

**Work Disability Risk:** Screen for risk factors for prolonged work disability. Physical examination may also capture evidence of risk factors such as fear/avoidance, emotional reactions, or pain behavior. Include mitigation strategy in the management plan. Document recommendations for mitigating work disability risk as counseling provided (with specifics) when using time-based coding. When using MDM-based coding, document work disability risk assessment and mitigation plans to support level of risk.

**Work Planning:** Include work status and return-to-work planning in every encounter, involving other parties (employer, WC case managers) as needed. Document return-to-work planning and case management activities as care coordination when using time-based coding.

history and examination findings (improvement, plateau, or progression); effectiveness of treatment, including the impact of medications or other treatment, the ongoing need for them, and any side effects; functional impact of the condition at home and at work; work status (whether the employee had returned to work or not, with or without modifications, full- or part-time, and reasons for not working if medically released to work); and relevant review of systems if the patient is not working or if any portion of the history suggests delayed recovery.

**Screening for Work Disability Risk**

Risk factors for poor recovery should be documented to support the management of functional impact/outcomes and risk of work disability. Screening for work disability risk is beyond the scope of this paper, but there are many different screening tools that have been developed and standardized to address psychosocial patient-specific as well as organizational risk factors for delayed recovery.<sup>24,26,27,33,53-55</sup> Screening for work disability risk may also be conducted informally by asking the patient about expectations and concerns related to returning to work. Responses may point to the need to explore further to identify risks such as pain catastrophizing,<sup>25,28</sup> fear/avoidance,<sup>25</sup> disability beliefs, injustice experience, work friction, and system barriers (Fig. 1). Such discussions relate to counseling and the need for care coordination (eg, potential need for behavioral health referral) and should be documented as such when using time-based coding. Screening for work disability risk also relates directly to the risk level documentation needed for MDM-based coding. Work disability risk should be addressed in the initial encounters and in later encounters if indicated.

**Documentation of the Physical Examination**

Physical examination appropriate to the work-related condition is integral to establishing patient trust while assessing function in a WC encounter. Although research has shown low reliability of physical examination conducted for low back pain,<sup>56</sup> one of the best studied common WC claimed conditions, accurate diagnosis may not be the only reason to perform a physical examination. Other research, although not specific to WC, has shown that patients expect physical examination and that it relates to their satisfaction with care.<sup>57</sup> Careful clinical observation can provide clues about work disability risk, for example, in a patient exhibiting fear of movement. The physician should explain the purpose of the examination procedures and seek the patient’s agreement before proceeding. General principles of physical examination for musculoskeletal conditions include documenting:

- Pertinent findings (positive or negative) on both the affected and unaffected side
- Patient level of distress
- Evaluation and documentation of functional status, for example:
  - Gait, posture, and balance
  - Ability to rise from chair or climb to/from table, with or without assistance of arms
  - Use of assistive devices
  - Demonstrations or tests of ability to use the affected body part
  - Simulation of work activities

**Management Planning**

Return to work should be addressed at the first meeting with the injured employee and updated at each additional visit. Because prolonged time off work will decrease the

**TABLE 1.** Types of Causation in WC

Causation Terms and Examples <sup>51</sup>		
WC Term	Definition	Case Example
Precipitation	Manifestation of previously latent condition	Asthma attack in laboratory animal worker with previous history of other allergies
Direct causation	Immediate effect of the job through direct sequence of events	Laceration of a hand caught in conveyor belt
Aggravation	Increase in severity of pre-existing condition	Worsening of pre-existing sports-related partial rotator cuff tear in warehouse employee diagnosed with a full tear after catching heavy box falling from shelf
Exacerbation	Temporary increase in severity of pre-existing condition	Provocation of pre-existing Raynaud’s in freezer warehouse employee
Acceleration	Hastened development of an underlying condition	Worsening of pre-existing carpal tunnel syndrome in a carpenter who needs surgery only in dominant wrist 2 y into the job
Consequential condition	Injury or illness secondary to treatment modalities, including prescription medication	Neuropathy secondary to treatment of work-related latent tuberculosis

WC, workers’ compensation.

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likelihood of eventual return to work, the first weeks of treatment are crucial in preventing and/or reversing chronicity and disability mindset.<sup>33,58</sup> Discussions with case managers or employers may be counted in the ACOEM proposed model as examples of obtaining an independent history or managing the patient in using MDM-based coding. Such discussions may be included as evidence of care coordination for time-based coding and should be documented.

ACOEM's Practice Guidelines are aligned with the principles of quaternary prevention, in recommending diagnostic testing and treatment that evidence has shown to be clinically necessary and least likely to cause harm to the worker. The online ACOEM Guidelines contain recommendations for use of diagnostic studies and treatment for some of the most important clinical situations in WC, including diagnostic testing for and treatment of low back pain, use of opioids, and occupational lung disease.<sup>6</sup> Related to this, time should also be spent discussing with workers the medications, tests, and procedures that are appropriate and *not appropriate* to order at the visit, when tests and treatment are appropriate, and documented as counseling. In other words, a treatment plan should be presented to and reviewed with the WC claimant on a regular basis in the context of shared decision-making.

Evaluation of risk of work disability is a critically important feature of WC encounters, and mitigation of this risk should be documented related to risk level in MDM-based coding and counseling or care coordination, as appropriate, using time-based coding. Work disability is a poor outcome with morbidity implications and should be addressed and managed as an important risk. Other examples of high-risk situations in a WC encounter include use of opioids (especially chronic use), pre-existing chronic musculoskeletal conditions, behavioral risks such as fear/avoidance and disability beliefs, and employer policies prohibiting return to work at less than full duty. All these situations should be documented as high risk and mitigation plans included in the patient management plan.

### Communication

Compared with encounters in other clinical specialties, a large amount of time may be spent on communication in a WC encounter owing to the emphasis on functional outcome and work planning. Time will be spent counseling and educating the employee on examination findings and planned next steps. The treating physician may need to communicate recommendations about mitigation measures to prevent future injuries or illnesses to other workers. Likewise, the physician may need to communicate with the employer to obtain more information that

**TABLE 2.** Rules for Applying Time Spent to Evaluation and Management Codes

Code <sup>43</sup>	Time
<b>New Patients*</b>	
99202	15–29 min
99203	30–44 min
99204	45–59 min
99205	60–74 min
<b>Established Patients</b>	
99211	N/A (minimal time, may not need physician)
99212	10–19 min
99213	20–29 min
99214	30–39 min
99215	40–54 min

\*ACOEM recommends that in WC, a new patient code can be used for a patient seen in the past 6 months if the encounter is for a new WC claim–related problem. This rule would need to be established by the WC system or payer.

ACOEM, American College of Occupational and Environmental Medicine; WC, workers' compensation.

will support causation analysis and return-to-work planning. Results and work recommendations such as return-to-work instructions, activity restrictions, and recommended accommodations will also need to be independently interpreted and communicated to the employee, family/caregiver, claims examiner, and employer. Referrals and communication with other healthcare professionals such as physical and occupational therapists (PT, OT), nurse practitioners (NPs), physician associates (PAs), medical consultants, and case managers are part of the care coordination of a typical WC case. The time spent on such discussions or form completion should be documented and counted as counseling and/or care coordination time in a time-based encounter. These activities may be documented as risk mitigation activities (preventing unnecessary work disability) when using MDM-based coding.

### Time-Based Coding

When using time-based coding, more than half of the encounter must be spent on counseling or care coordination activities, and these must be documented. Select the code based on total time spent caring for the patient on the date of the encounter (Table 2). Total time includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional (as defined by the relevant jurisdiction) on the encounter date. Clinical staff time is not counted. There is no need to separately document time spent counseling. Examples of WC-relevant counseling or care coordination activities are as follows:

- Discussing related medications, tests, and procedures not appropriate to order at this visit
- Requesting worksite information such as industrial hygiene measurements or ergonomic evaluations

- Referring/communicating with other health care professionals when not reported separately (includes other health care professionals treating the same patient, such as PT, OT, NPs, PAs, physicians, medical director, or nurse from insurance carrier or third-party administrator)
- Communicating results or work recommendations to patient, family, caregiver, claims examiner, employer, and/or case manager when not reported separately (return-to-work instructions; activity restrictions; evaluating relationship of physical exam findings, history, job description, and mechanism of injury)
- Care coordination when not reported separately (case manager; discharge instructions for postoperative care)
- Need to include interpreter for obtaining history, providing counseling, instructions
- Time spent on causation or apportionment analysis, as this is relevant to care authorization and treatment decisions

### MDM-Based Coding

Although there is MDM in virtually all encounters, here MDM refers to the specific system of documenting elements of care that are used to assign a level of care (and payment) for an encounter. Per the 2021 CMS rules, E&M encounters may use either time-based coding or MDM-based coding. There are times when it may be more appropriate to code E&M encounters for WC care using MDM criteria rather than time. This includes encounters when there was little time spent on counseling, but the clinical situation is a highly complex, high-risk situation. It is important to understand the criteria used to assign a specific level of complexity based on MDM, which takes into consideration the following:

- Number and complexity of patient problems

- Amount of data reviewed and
- Level of risk

ACOEM has proposed several WC-relevant variations from the examples provided by CMS for these categories, based on the type of data reviewed in occupational medicine practice and the types of risk. Importantly, ACOEM recognizes and therefore includes work disability under morbidity risk considerations. See the ACOEM Tip Sheet<sup>45</sup> for the documentation requirements at each level of care for WC encounters, with ACOEM-proposed variations (eg, reviewing a job description or industrial hygiene report would

be counted as data reviewed) compared with the examples appropriate for other types of care. In WC outpatient care, there is little use of risky diagnostic procedures or treatment options, however, there may be the need for substantial time and effort to address risk for work disability, which we consider a severe negative outcome. Note that in the high-risk category, the risk assigned for management options selected usually refers to the risk of not managing related problems in a WC case (rather than the inherent clinical risk of diagnostic or treatment procedures) and considers the complexities of the management plans for high-risk situations like ongoing

opioid use and prolonged work disability. Figure 4 provides a comparison of time- versus MDM-based coding in two cases.

### CONCLUSION

Outpatient care for WC injuries or illness is coded as E&M encounters, with rules for documentation and coding level of care established by CMS. Although coded the same as primary care, urgent care, or other outpatient care encounters, there are important documentation and care needs in WC encounters that differ from other clinical care in several important ways: the need to determine and

#### Time or MDM? Examples

**Case 1** A 30-year-old police officer who worked for several hours removing multiple vehicles' interior console parts with crowbar/prybar to reach airbag computer unit, presents two days later complaining of back pain. There is no significant past medical history, no red flags on history or exam and she appears motivated to recover and return to work. There is no data to review. You spend 15 minutes with her.

Using time-based coding, the level of service is 99202. Using MDM-based coding, the level of service is 99203. In this case, it would be beneficial to use MDM-based coding.

Time-Based Coding	
Code	Time
99211	N/A
99202*	15-29 minutes
99212	10-19 minutes
99203*	30-44 minutes
99213	20-29 minutes
99204*	45-59 minutes
99214	30-39 minutes
99205*	60-74 minutes
99215	40-54 minutes

Code	Level of MDM	Criteria		
		Number & Complexity of Problems	Amount and/or Complexity of Data	Risk
99203 99213	Low	<ul style="list-style-type: none"> <li>• 2 or more self-limited or minor problems</li> <li>• 1 stable chronic illness</li> <li>• 1 acute, uncomplicated illness or injury</li> </ul>	Elements of MDM [2 of 3] Category 1: Tests and documents: Any 2 of 3 of these: <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source</li> <li>• Review of the result(s) of each unique test</li> <li>• Ordering of each unique test</li> </ul> OR Category 2: Assessment requiring an independent historian(s)	Low risk of morbidity

**Case 2** A 60-year-old dining services employee, a new patient to your practice, comes 3 days after a visit to the emergency department for acute low back pain with onset after lifting a heavy pot. Past history of car accident and chronic low back pain managed with opioids. He has been inconsistent with physical therapy and other non-opioid approaches to back pain in the past. There is no data to review. You spend 60 minutes with him exploring his work disability risk factors and pain management.

Using time-based coding, the level of service is 99205. Using MDM-based coding (and counting the opioid use as moderate risk criterion), the level of service is 99204. In this case, time-based coding makes more sense.

Time-Based Coding	
Code	Time
99211	N/A
99202*	15-29 minutes
99212	10-19 minutes
99203*	30-44 minutes
99213	20-29 minutes
99204*	45-59 minutes
99214	30-39 minutes
99205*	60-74 minutes
99215	40-54 minutes

Code	Level of MDM	Criteria		
		Number & Complexity of Problems	Amount and/or Complexity of Data (1 of 3)	Risk
99204 99214	Moderate	<ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or</li> <li>• 2 or more stable chronic illnesses; or</li> <li>• 1 undiagnosed new problem with uncertain prognosis; or</li> <li>• 1 acute illness with systemic symptoms; or</li> <li>• 1 acute complicated injury</li> </ul>	Elements of MDM [2 of 3] Category 1: Review, ordering or interpreting tests, documents, or obtaining external history (at least 3 types) Category 2: Independent interpretation of tests performed elsewhere Category 3: Discussion of management or test interpretation with an external person	Moderate risk of morbidity

FIGURE 4. Examples comparing coding using time versus Medical Decision-Making (MDM).<sup>44</sup>

document work causation, evaluation and mitigation of risk of chronic work disability, application of occupational medicine practice guidelines, and time needed for careful return-to-work planning. The 2021 updates to CMS coding rules allow for both time-based coding and MDM coding for these encounters. This paper has outlined the key elements of care in high-value WC encounters and introduced best practices of coding with either model. As the cost of work injury and illness continues to balloon, the provision of quality and high-value care will remain a top priority for employers, health systems, and payers. Proper documentation of quality care in WC encounters has the potential to reduce delays in the treatment and improve clinical and return-to-work outcomes, while ensuring that physicians and other treating clinicians are fairly compensated for this care.

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