**Colossus and other computer software programs**

**Day 1:**

**\*MVA History**

**Affidavit of Injury**

**Settlement Agreement**

**Assignment of Benefits**

**Exam**

**\*Diagnosis**

**Treatment Recommended**

**\*Duties Under Duress**

**\*X-ray**

**Treatment – 9894X, 97124, 97110, 97012, 97014, 97010, 97035 - roller tables**

**Initial Report – 99203/99214**

**Day 2:**

**\*Condition Specific Outcome Assessment**

**\*Muscle Testing**

**\*ROM – inclinometer or goniometer**

**97750 for each 15 minutes - $75/unit (Can’t bill for Day 2)**

**\*Myovision**

**96002 – Test**

**96004 – Interp**

**Daily Visit**

**Manipulation (can’t bill 97140 in same region)**

**Ultrasound**

**Heat/Ice**

**Electric Stim – 97014 or 97132 if attended (change settings every 10 min or so)**

**Ther Ex**

**NMR – Only use when significant loss of muscle function**

**Massage – reduce spasm and increase circulation**

**Re-exam (every 2-4 weeks)**

**Repeat Day 2**

**\*Update prognosis on each evaluation**

**Final**

**\*Loss of Enjoyment of Life, etc. ; Duties Under Duress**

**\*Final Impairment**

**Sample Initial PI Narrative**

**Detailed Musculoskeletal Examination**

Patient Name: Joe Doe Date: 07-27-2015

Gender: Male

ID #: XXX-XX-1234

**CHIEF COMPLAINT:** Neck pain in back of neck on right side, front side, headaches, nausea, tightness in back of neck and right side of front neck, depression, tired, right jaw pain, loss of sleep.

**HISTORY**

**History of Present Illness**

Date of First Symptom: 07-24-2015

How Incident Occurred: Patient was rear-ended in their Toyota Prius while stopped at a red light by a Ford F-150 pick up truck.

Location of Symptoms: Neck, jaw on right side, headaches.

Pain Scale (0-10): Neck 7, Jaw 5, Headaches 8.

Aggravating/Relieving Factors: Nothing so far

Radiating Symptoms: Head

**Review of Systems**

Musculoskeletal: Other than the chief complaint, the patient reports no other pain, spasm, decreased motion with their musculoskeletal system.

Neurological: The patient denies dizziness, vomiting, ringing in the ears and numbness/tingling in the face and extremities.

**Past Health History**

Injuries: None

Surgery: None

Medication: For allergies

**Social History**

Work: Patient is a barrister at Coffee Bean.

Exercise: Infrequent

*(The above information constitutes an extended HPI and ROS and a pertinent PSH. This is a detailed history per the AMA-CPT codebook and the 1997 DG.)*

**EXAMINATION**

Constitutional:

* The patient’s height is 5’ 10”; weight 165 lbs. Sitting blood pressure: 110/75, pulse rate: 74 and respiration: 24 b.p.m.
* Observation of the patient’s general appearance revealed a person who is well developed, of adequate nutrition, seems to be well groomed and maintained and without any apparent deformities.

Musculoskeletal:

* The patient’s gait and station is guarded due to neck pain.

An examination was performed of the joints, bones, muscles and tendons of the areas listed below. (Each bullet counts once for each area of the body listed below)

* The examination consisted of inspection, percussion, and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses/effusions;
* Assessment of range of motion with notation of any pain, crepitation or contracture;
* Assessment of stability with notation of any dislocation, subluxation or laxity;
* Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements. All finding are normal unless noted as otherwise below.

**Head and Neck:** There is pain and tenderness upon palpation noted at C1-C5 bilaterally. Fixations were noted at C2, 3, 4, 5. There is decreased ROM noted on all axis especially. There was muscle tightness and spasm at C2, 3, 4, 5 bilaterally.

Skin

* Inspection and/or palpation of skin and subcutaneous tissue (e.g. scars, rashes, lesions, café-au-lait spots, ulcers) were performed in 4 of the following 6 areas. All finding are normal unless noted as otherwise below.

Head and Neck: WNL

Neurological:

* The patient was well oriented to time, space and person.
* Recent and remote memory appeared to be intact.
* The patient’s attention span and memory appeared normal.
* There did not appear to be difficulty with language or general awareness.
* Sensation of the extremities was tested and found to be WNL.
* Examination of the deep tendon reflexes were tested and found to be WNL.

*(Twelve or more elements of this exam were performed. This is considered a detailed exam per the AMA-CPT codebook and the 1997 DG.)*

**Cervical Spine X-Ray**

There is no evidence of fracture, dislocation or neoplasm. The lung apices are clear and well aerated. There is no elongation of the transverse processes of C7. There are no cervical ribs appreciated. There is (no/mild/moderate/severe) (dextro/levo) scoliosis in the cervical spine.

The cervical lordosis is (normal/decreased/straightened/reversed). Flexion and extension studies are normal. There is no increase in the ADI space on flexion. AP open mouth reveals an intact dens.

(No/mild/moderate/severe) degeneration is appreciated (at ---). There is no foraminal encroachment appreciated on these views.

George’s line is (broken/unbroken) indicating probable ligamentous laxity.

**Thoracic Spine X-Ray**

There is no evidence of fracture, dislocation or neoplasm. The lung fields are clear and without obstruction. The bony thorax is normal. There is disc space narrowing at --- and osteophytes off the lateral edge of ---. There is a moderate increase in the thoracic kyphosis.

**Lumbosacral Spine X-Ray**

There is no evidence of fracture, dislocation or neoplasm. There is minor pelvic head unleveling on the --- (with/without) a compensatory scoliosis. Further postural evaluation for a functional may be related. Inspection of the sacroiliac and hip joints show no articular changes.

There are no osteophytes on the anterior borders of the vertebral bodies from L1 to L5. There is a slight flattening of the normal lordotic curve that suggests muscle weakness of the spinal and/or abdominal muscles. There is mild facet arthrosis appreciated at ---. There is disc space narrowing at --- with a ---% loss in disc height.

There are no pars defects or spondylolisthesis noted. Flexion and extension views show no evidence of intersegmental instability.

(broken/unbroken) indicating ligamentous laxity.

**Diagnosis:**

**Prognosis:**

**Treatment Recommendations:**

**LEVEL OF MEDICAL DECISION MAKING:** Low to Moderate per the AMA-CPT codebook and 1997 DG.

**Treatment Plan:** The duration of care is estimated to be \_\_\_\_\_\_\_\_\_ weeks. During that time period, the patient will be treated \_\_\_\_\_\_\_\_\_ times per week until a follow up re-evaluation.

**Treatment Goals:** The goal of treatment is to decrease the patient’s pain level by --% and increase joint range of motion by -- % or more within the next 2 to 4 weeks.

**Causation:** Based on the patient’s history and my physical exam findings, it is my opinion that -- in all reasonable medical probability -- the patient’s injuries were the direct result of the motor vehicle accident that took place on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Time**: The time of the examination was \_\_\_ minutes, which included face-to-face time by ancillary staff as well. Counseling and/or coordination of care did **not** exceed the majority of the visit; therefore, time was not used as the determining factor for selecting the appropriate E/M code. The E/M code was derived from the patient’s history, examination and medical decision-making.

CPT Code: 99203 for a new patient and 99214 for an established patient. This is according to the AMA-CPT codebook and the 1997 DG.

Sincerely,