Exhibit #7

Evaluation and Management (E&M) Documentation Guidelines for Colorado Workers' Compensation Claims

Effective for Dates of Service on and after 1/1/2019

This E&M Guidelines for Colorado Workers' Compensation Claims is intended for the providers who manage injured workers' medical and non-medical care. Providers may also use the "1997 Documentation Guidelines for Evaluation and Management Services" as developed by Medicare. The Level of Service is determined by these three components:

1. History (Hx),
2. Examination (Exam), and
3. Medical Decision Making (MDM)

OR Time (as per CPT© and Rule 18)

Documentation requirements for any billed office visit:

- Chief complaint and medical necessity.
- Patient specific and pertain directly to the current visit.
- Information copied directly from prior records without change is not considered current or counted.
- CPT© criteria for a consultation is required to bill a consultation code.

Table I – History (Hx) Component: All three elements in the table must be met and documented.

HISTORY ELEMENTS	Requirements for a Problem Focused (PF) Level	Requirements for an Extended Problem Focused (EPF) Level	Requirements for a Detailed (D) Level	Requirements for a Comprehensive (C) Level
A. History of Present Illness/Injury (HPI)	1-3 elements	1-3 elements	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs)**	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs)**
B. Review of Systems (ROS)	Present	Present	Present	Present
C. Past Medical, Family and Social/Work History (PMFSH)	None	None	Pertinent 1-2 types of histories	Pertinent 3 or more types of histories

A. HPI Elements represents the injured worker relaying their condition to the physician and should include the following:

1. Location (where?)
2. Quality (sharp, dull?)
3. Severity (pain level 1-10 or pain diagram)
4. Duration (how long?)
5. Timing (how often, regularity of occurrence, only at night, etc.?)
6. Context (what ADLs or functions aggravates/relieves, accident described?)
7. Modifying factors (doing what, what makes it worse or better?)
8. Associated signs (nausea, numbness or tingling when?)

For the provider to achieve an *"extended" HPI* in an initial patient/injured workers visit it is necessary for the provider to discuss the causality of the patient/injured worker's work related injury(s) to the patient/injured worker's job duties.

For the provider to achieve an *"extended" HPI* in an established patient/injured worker visit it is necessary to document a detailed description of the patient's progress since the last visit with current treatment plan that includes patient pertinent objective functional gains, such as ADLs, physical therapy goals and return to work.

B. Review of Systems (ROS): Review of systems should be qualitative versus quantitative, documenting what is pertinent to that patient for the date of service.

1. Constitutional symptoms (e.g., fever, weight loss)
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin and/or breast)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

C. PMFSH consists of a review of four areas (NOTE: Employers should **not** have access to any patient's or the family's genetic/hereditary diagnoses or testing information, etc.)

1. Past history – the patient's past experiences with illnesses, operations, injuries and treatments.

2. Family history – a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk and any family situations that can interfere with or support the injured worker's treatment plan and returning to work.

3. Occupational/Social History/Military – an age appropriate review of past and current work activities, occupational history, current work status, any work situations that support or interfere with return to work. For established visits specific updates of progress must be discussed.

4. Non-Occupational/Social History – Hobbies, current recreational physical activities and the patient's support relationships, etc. For established visits specific updates of progress must be discussed.

TABLE II: Examination Component: Each bullet is counted only when it is pertinent and related to the workers' compensation injury and the medical decision making process.

Physician's Examination Component	
Level of Examination Performed and Documented	**# of Bullets Required for each level**
Problem Focused	1-5 elements identified by a bullet as indicated in the guideline
Expanded Problem Focused	6 elements identified by a bullet as indicated in this guideline
Detailed	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive	≥13 elements identified by a bullet as indicated in this guideline

Examination Components:

Constitutional Measurement:

- Vital signs (may be measured and recorded by ancillary staff) – any of three (3) vital signs is counted as one bullet:
  1. sitting or standing blood pressure
  2. supine blood pressure
  3. pulse rate and regularity
  4. respiration
  5. temperature
  6. height
  7. weight or BMI
- One bullet for commenting on the general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal: Each of the six body areas with three (3) assessments is counted as one bullet.

1. head and or neck
2. spine or ribs and pelvis or all three
3. right upper extremity (shoulder, elbow, wrist, entire hand)
4. left upper extremity (shoulder, elbow, wrist, entire hand)
5. right lower extremity (hip, knee, ankle, entire foot)
6. left lower extremity (hip, knee, ankle, entire foot)

Assessment of a given body area includes:

- Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain (e.g., straight leg raise), crepitation or

contracture

- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes)

Gait and Station: assessment equals one bullet

Neck: One bullet for both examinations.

- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) and
- Examination of thyroid (e.g., enlargement, tenderness, mass)

Neurological: One bullet for each neurological examination/assessment(s) per extremity.

1. Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities)
2. Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
3. Examination of sensation (e.g., by touch, pin, vibration, proprioception)
4. One bullet for all of the 12 cranial nerves assessments with notations of any deficits

Cardiovascular:

1. One bullet per extremity examination/assessment of peripheral vascular system by:
    a. Observation (e.g., swelling, varicosities)
    b. Palpation (e.g., pulses, temperature, edema, tenderness)
2. One bullet for palpation of heart (e.g., location, size, thrills)
3. One bullet for auscultation of heart with notation of abnormal sounds and murmurs
4. One bullet for examination of each one of the following:
    a. carotid arteries (e.g., pulse amplitude, bruits)
    b. abdominal aorta (e.g., size, bruits)
    c. femoral arteries (e.g., pulse amplitude, bruits)

Skin: One bullet for pertinent body part(s) inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café au lait spots, ulcers)

Respiratory: One bullet for each examination/assessment.

1. Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
2. Percussion of chest (e.g., dullness, flatness, hyperresonance)
3. Palpation of chest (e.g., tactile fremitus)
4. Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Gastrointestinal: One bullet for each examination /assessment.

1. Examination of abdomen with notation of presence of masses or tenderness and liver and spleen

2. Examination of presence or absence of hernia

3. Examination (when indicated) of anus, perineum and rectum, including sphincter tone, present of hemorrhoids, rectal masses and/or obtain stool sample of occult blood test when indicated

Psychiatric:

1. One bullet for assessment of mood and affect (e.g., depression, anxiety, agitation) if not counted under the Neurological system

2. One bullet for a mental status examination which includes:

a. Attention span and concentration; and

b. Language (e.g., naming objects, repeating phrases, spontaneous speech) orientation to time, place and person; and

c. Recent and remote memory; and

d. Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

Eyes: One bullet for both eyes and all three examinations/assessments.

1. Inspection of conjunctivae and lids; and

2. Examination of pupils and irises (e.g., reaction of light and accommodation, size and symmetry); and

3. Opthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Ears and Nose, Mouth and Throat:

One bullet for all of the following examination/assessment:

1. External inspection of ears and nose (e.g., overall appearance, scars, lesions, asses)

2. Otoscopic examination of external auditory canals and tympanic membranes

3. Assessment of hearing with tuning fork and clinical speech reception thresholds (e.g., whispered voice, finger rub, tuning fork)

One bullet for all of the following examinations/assessments:

1. Inspection of nasal mucosa, septum and turbinates

2. Inspection of lips, teeth and gums

3. Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)

Genitourinary MALE: One bullet for each of the following examination of the male genitalia:

1. The scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)

2. Epididymides (e.g., size, symmetry, masses)

3. Testes (e.g., size symmetry, masses)

4. Urethral meatus (e.g., size location, lesions, discharge)

5. Examination of the penis (e.g., lesions, presence of absence of foreskin, foreskin retract ability, plaque, masses, scarring, deformities)

6. Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)

7. Inspection of anus and perineum

Genitourinary FEMALE: One bullet for each of the following female pelvic examination(s) (with or without specimen collection for smears and cultures):

1. Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele rectocele)
2. Examination of urethra (e.g., masses, tenderness, scarring)
3. Examination of bladder (e.g., fullness, masses, tenderness)
4. Cervix (e.g., general appearance, lesions, discharge)
5. Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
6. Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest: One bullet for both examinations/assessments of both breasts.

1. Inspection of breasts (e.g., symmetry, nipple discharge); and
2. Palpation of breasts and axillae (e.g., masses or lumps, tenderness)

Lymphatic palpation of lymph nodes: Two or more areas is counted as one bullet.

1. Neck
2. Axillae
3. Groin
4. Other

Verify all of the completed examination components listed in the report documents the relevance/relatedness to the injury and or "reasonable and necessity" for that specified patient's condition. Any examination bullet that is not clearly related to the injury or a patient's specific condition will not be counted/considered in the total number of bullets for the level of service.

TABLE III: Medical Decision Making Component (MDM): TABLES A, B, AND C

Overall MDM is determined by the highest 2 out of 3 categories below:

Table III.

Medical Decision Making (MDM) Component			
Type of Decision Making	**A. # of Points for the # of Diagnosis and Management Options**	**B. # of Points for Amount and Complexity of Data**	**C. Level of Risk**
Straightforward	0-1	0-1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4+	4+	High

TABLE III A:

A. Number of Diagnosis & Management Options					
Category of Problem(s)	**Occurrence of Problem(s)**		**Value**		**Total**
Self-limited or minor problem	(max 2)	X	1		
Established problem, stable or improved		X	1		
Established problem, minor worsening		X	2		
New problem with no additional workup planned or established patient with worsening of condition and no additional workup planned	(max 1)	X	3		
New problem, additional workup planned or established patient with less than anticipated improvement or worsening of condition and additional workup planned		X	4		

TABLE III B:

B. Amount and/or Complexity of Data Reviewed	
Date Type:	Points
Lab(s) ordered and/or reports reviewed	1
X-ray (s) ordered and/or reports reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Medicine section (90701-99199) ordered and /or physical therapy records reviewed and commented on progress state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care	2
Review and summary of old records and/or discussion with other health provider	2
Independent visualization of images, tracing or specimen	2
TOTAL	

TABLE III C:

C. Table of Risk (the highest one in any category determines the overall risk for this portion.)			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Option(s) Section**
Minimal	One self-limiting or minor problem, e.g., cold, insect bite, tinea corporis, minor non-sutured laceration.	Lab tests requiring venipuncture; Chest X-rays; EKG, EEG; Urinalysis; Ultrasound; 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 HTN, DM2, cataract, BPH; Acute, uncomplicated illness or injury, e.g., allergic rhinitis, sprain.	Physiologic tests not under stress, e.g., PFTs; Non-cardiovascular imaging studies with contrast, e.g., barium enema; Superficial needle biopsy; ABG; Skin biopsies	Over the counter drugs; Minor surgery with no identified risk factors; PT/OT; IV fluids w/o additives; Simple or layered closure; Vaccine injection
Moderate	One or more chronic illness with mild exacerbation, progression or side effects of treatment; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints; Acute illness with systemic symptoms, e.g., pyelonephritis colitis; Acute complicated injury, e.g., head injury, with brief loss of consciousness.	Physiologic tests under stress, e.g., cardiac stress test; Discography; Diagnostic injections; Deep needle, or incisional biopsies; Cardiovascular imaging studies, with contrast, and no identified risk factors, e.g., arteriogram, cardiac catheterization; Obtain fluid from body cavity, e.g., LP/thoracentesis.	Minor surgery, with identified risk factors; Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors; Prescription drug management; Therapeutic nuclear medicine; IV fluids, with additives; Closed treatment of fracture or dislocation, without manipulation; Inability to return the injured worker to work and requires detailed functional improvement plan.

High	One or more chronic illness, with severe exacerbation, progression or side effects of treatment; Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss.	Cardiovascular imaging studies with contrast, with identified risk factors; Cardiac EP studies; Diagnostic endoscopies, with identified risk factors.	Elective major surgery (open, percutaneous, endoscopic), with identified risk factors; Emergency major surgery; Parenteral controlled substances; Decision not to resuscitate, or to de- escalate care because of poor prognosis; Potential for permanent work restrictions or total disability which would significantly restrict employment opportunities; Management of addiction behavior or other significant psychiatric condition; Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological findings or verified related medical diagnosis.

Time Component:

- If greater than 50% of a physician's time at an E&M visit is spent either face-to-face with the patient counseling and/or coordination of care, with or without an interpreter, and there is detailed patient specific documentation of the counseling and/or coordination of care, then time can determine the level of service.
- If time is used to establish the level of visit and total amount of time falls in between two levels, then the provider's time shall be more than half way to reaching the higher level.

A. Counseling: Primary care physicians should have *shared decision making conferences* with their patients to *establish viable functional goals* prior to making referrals for diagnostic testing and/or to specialists. Shared decision making occurs when the physician shares with the patient all the treatment alternatives reflected in the Colorado Medical Treatment Guidelines as well as any possible side effects or limitations, and the patient shares with the primary physician their desired outcome from the treatment. Patients should be encouraged to express their goals, outcome expectations and desires from treatment as well as any personal habits or traits that may be impacted by procedures or their possible side effects.

1. The physician's time spent face-to-face with the patient and/or their family counseling him/her or them in one or more of the following:

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

B. Coordination of Care: Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient's diagnosis and/or treatment or the physician telephones or visits the employer in person to safely return the patient to work.

Table V: New Patient/Office Consultations Level of Service: CPT consultation criteria must be met before a consultation can be billed for any level of service.

New Patient/ Level of Service (requires all three key components at the same level or higher)	**History**	**Examination**	**Medical Decision Making (MDM)**	**Average Time** (minutes) as listed for the specific CPT© code
99201/99241	Problem Focused (PF)	PF	Straight Forward (SF)	10
99202/99242	Extended PF	EPF	SF	20
99203/99243	Detailed (D)	D	Low	30
99204/99244	Comprehensive (C)	C	Moderate	45
99205/99245	Comprehensive (C)	C	High	60

Table VI: Established Patient Office Visit Level of Service

Established Patient/ Level of Service (Requires at least **two of the three key** components at the same level or higher and one of the two must be MDM)	**History**	**Examination**	**Medical Decision Making (MDM)**	**Average Time** (minutes) as listed for the specific CPT© code
99211	N/A	N/A	N/A	5
99212	Problem Focused (PF)	PF	SF	10
99213	Extended PF	EPF	Low	15
99214	Detailed (D)	D	Moderate	25
99215	Comprehensive (C)	C	High	40