Outpatient Osteopathic SOAP Note—Follow-up Form

Usage Guide

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Signature of examiner:

Signature of transcriber: _

Outpatient Osteopathic SOAP Note—Follow-up Form

Patient's Name

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Signature of transcriber:

Signature of examiner:

Signature of examiner:

Outpatient Osteopathic SOAP Note---Follow-up Form

Introduction:

The following Outpatient Osteopathic SOAP Note Follow-up Form was developed by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee under a grant from the American Osteopathic Association. This valid, standardized, and easy to use form is our best recommendation to the Osteopathic Profession for research and training in osteopathic medicine.

Instructions for use:

Print where stated. All printing or writing must be legible to anyone, otherwise the record is useless. Blacken the appropriate rectangles. Data can be collected and analyzed by a computer. Additions to the form can be made. If data were not obtained for a certain section, leave it blank or fill in the "not done" rectangle. All definitions were obtained from the CPT book and the Glossary of Osteopathic Terminology. The headings are presented and arranged as they appear on the form, beginning with the upper left-hand corner and reading to the right and down. Bold text in this Usage Guide corresponds to Form text.

Page 1 of 2 "S" Subjective and "O" Objective Form

Section 1: Patient's Identification and Vital Signs

Patient's Name: Write in the patient's first and last name

Date: Write in the date of this visit. Use the following format for all dates: month/day/year.

Sex: Fill in the box after **Male** or **Female** with regards to the patient's gender.

Age: Write in the patient's age in years. If a child, use days up to 1 month, use months up to 1 year, and years of age.

Vital Signs: Write in the corresponding vital signs on the lines provided. Three (3) of the seven (7) listed are needed to fulfill the requirements for a comprehensive examination. The seven include:

1. Wt. (weight in pounds, lbs.), 2. Ht. (height in feet and inches, ft., in.), 3. Temp. (temperature in degrees Fahrenheit), 4. Resp. (rate of respiration in breaths-per-minute), 5. Pulse (in beats per minute) and whether it is regular (Reg.) or irregular (Irreg.), 6. BP (blood pressure)

Standing, Sitting, and 7. BP Lying down. If a measurement was not taken, leave the space blank.

The boxes marked **Office of:** and **For office use only:** can be used for tracking a research study, for office record keeping, etc.

Section II: "S" Subjective

S: for the **Subjective** part of the SOAP Note.

Patient's Pain Analog Scale: The patient is asked to place a mark on the 0-10 analog scale indicating the degree of pain he/she has at the time of this interview. Patients are given the following instructions: "If you have NO PAIN, place a mark at the far left side. If this is the WORST POSSIBLE PAIN you have ever experienced, indicate it at the far right side. Indicate where your pain is at this time." If the patient doesn't have pain or this information was not obtained, fill in the "Not done" rectangle.

CC Stands for Chief Complaint, which is a concise statement describing the symptoms, problem, condition, diagnosis or other factors that are the reason for the encounter. CC usually is stated in the patient's words. Write the CC in the open area next to the meds section.

HPI Stands for History of Present Illness, which is a chronological description of the development of the patient's present illness, from the first sign and/or symptom to the present. This includes a description of location, quality, severity, duration, timing, context, modifying factors, and

associated signs and symptoms significantly related to the presenting problem(s). Write the **HPI** in the open area next to the meds section and check off those descriptors included to the right of the HPI title. The HPI might also include the status of 3 or more chronic or inactive conditions.

PFSH Stands for Past Medical, Family, Social **History.** The **Past History** is a review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about: prior major illnesses and injuries, prior operations, prior hospitalizations, allergies, age-appropriate immunization status, and age-appropriate feeding/dietary status. The **Family History** is a review of medical events in the patient's family that include significant information about: the health status or cause of death of parents, siblings, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or Systems Review; diseases of family that may be hereditary or place the patient at risk. The **Social History** is an age-appropriate review of past and current activities that includes significant information about: marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol, and tobacco; level of education; sexual history; other relevant social factors. Write the **PFSH** in the open area next to the meds section.

ROS Stands for **Review of Systems** which is an inventory of body systems, pertinent to the chief complaint, that are obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. ROS is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. For the purposes of CPT, the following systems review has been identified: Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI (Gastrointestinal), GU (Genitourinary), Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, and Allergic/Immunologic. The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data for other systems that might be affected by any possible management options. Write the **ROS** in the open area next to

the meds section and check off those descriptors included to the right of the ROS title.

Meds: Write in the current **Medications**, dosage, route and frequency of administration.

Level: HPI: This is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. Circle the Roman numeral that applies. The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level II (99212) or III (99213) code requires 1-3 HPI elements to qualify. A level IV (99214) or V (99215) code requires 4+ HPI elements OR mention of the status of ≥ 3 chronic conditions.

Level: ROS: The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level II (99212) requires no (none) ROS. Level III (99213) requires 1 ROS pertinent to the problem. Level IV (99214) requires 2-9 ROS. Level V (99215) requires listing of 10+ ROS. Circle the Roman numeral that applies.

Level: PFSH: The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level II (99212) and III (99213) requires that no (none) history areas be present. Level IV (99214) requires 1 PFSH area. Level V (99215) requires 2+ PFSH areas. Circle the Roman numeral that applies.

Overall History: Fill in the rectangle that indicates the average level determined using the level of HPI, ROS or PFSH provided. A level II includes 1-3 HPI. A level III includes 1-3 HPI and 1ROS. A level IV includes 4+ HPI, 2-9 ROS and 1 PFSH. A level V includes 4+ HPI, 10+ ROS and 2+ PFSH.

Section III: "O" Objective

O: for the Objective part of the SOAP Note. Physical exam findings for any areas/systems of the General Multi-System Examination (GMS) are recorded in this section. These include: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Neck, Cardiovascular, Respiratory, Chest (Breasts), Gastrointestinal (Abdomen), Genitourinary, Lymphatic, Musculoskeletal, Skin, Neurologic, and Psychiatric. The table that follows on page 2 of 2 provides a section

where specific somatic dysfunctions of the musculoskeletal exam can be recorded and documented.

Horizontal Planes (Diagram): The diagram can be used to indicate levelness of landmarks, such as mastoid processes, shoulders, inferior angle of the scapula, iliac crests, and the superior border of the greater trochanters. (This same diagram can also be used to denote such things as lateral curvatures, the AP weight bearing line, or any other documentation that may be helpful.)

Level of GMS (General Multi-System): This is a guide for criteria needed to justify your evaluation and management CPT code in the Objective section. See the CPT book for details and definitions of elements. Fill in the rectangle that represents the level that applies.

- II 1-5 elements: For a level II (99212) visit you must have examined one to five elements identified by a bullet.
- **III 6+ elements:** For a level **III** (99213) visit you must have examined at least six elements identified by a bullet.
- IV 2+ from each of 6 areas OR 12+ elements in 2+ areas: For a level IV (99214) visit you must have done an examination of at least two elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems.
- V 2+ elements from each of 9 areas:
 For a level V (99215) visit, you must perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.

Be advised that for the **Musculoskeletal Exam**, the six areas are: (1) head, face, and neck; (2) spine, ribs, and pelvis; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; (6) left lower extremity.

Warning: For a comprehensive level of exam, all four of the elements identified in TART must be performed and documented for each of four of the six anatomic areas plus examination of gait and station and inspection and/or palpation of digits and nails. For the three lower levels of examination, each element is counted separately

for each body area. For example, assessing range-of-motion in two extremities constitutes two elements.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

Page 2 of 2 "O" Objective Findings (cont.):
"A" Assessment and "P" Plan Form

Section I: Patient's Name and Date

Patient's Name: Write in the patient's first and last name

Date: Write in the date of the patient's visit (month/day/year).

The boxes marked **Office of:** and **For office use only:** can be used for tracking a research study, for office record keeping, etc.

<u>Section II: Objective Findings (cont.):</u> <u>Musculoskeletal Table</u>

Exam Method Used: Be sure to place an oblique line through the box indicating the tools used for your examination (**T**, **A**, **R**, **T**). Included in the definition of these components are the criteria required for coding in each body area.

- All: Indicates that all **TART** criteria were used to examine a region
- **T: Tissue Texture Change,** stability, laxity, effusions, tone
- **A: Asymmetry,** misalignment, crepitation, defects, masses
- R: Range-of-Motion, contracture
- T: Tenderness, pain

Filling in the rectangles is a shortcut to a full narrative documentation in the **Somatic Dysfunction/Other** section of this table.

Region Evaluated: This is a list of musculoskeletal body regions arranged in order based on the CPT examination documentation requirements. They include: *1. Head and Face, and Neck; *2. The spine (Thoracic, Ribs, Lumbar, Sacrum/Pelvis, Pelvis/Innom., and

Abd./Other); *3. Right Upper Extremity; *4. Left Upper Extremity; *5. Right Lower Extremity; and *6. Left Lower Extremity. The thoracic region is broken down into three parts based on vertebral levels for innervation specificity: T1-4, T5-9, and T10-12. This provides for ease in listing interrelationships between musculoskeletal findings and possible involvement of the visceral system.

Severity: This section refers to the severity [None (0), mild (1), moderate (2), severe (3)] of the most affected somatic dysfunction in a region. Fill in a rectangle for each region examined. For regions that are not examined, leave the rectangle empty.

If a rectangle is **not marked** in a region, it is assumed that that region was **not examined**. For regions that are examined, the scale is as follows:

0 None No somatic dysfunction

present or background (BG)

level.

1 Mild More than background level,

minor TART elements.

2 Moderate Obvious **TART**; in particular

Range-of-motion (R) and/or Tissue texture change (T) may

or may not be overtly

symptomatic.

3 Severe Key lesions observed,

significant, symptomatic, stands out; **R** and/or **T** elements stand out with minimum search or

provocation.

(At the top of the table is a **Key to the Severity Scale**, which provides for a quick review.)

Somatic Dysfunction/Other: Somatic Dysfunction is defined as impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial, and myofascial structure, and related vascular, lymphatic, and neural elements. In this section for each region assessed, write your somatic dysfunctions, including musculoskeletal (MS), sympathetic nervous system (SNS), parasympathetic nervous system (PNS), lymphatic (LYM), cardiovascular (CV), respiratory (RESP), gastrointestinal (GI), fascial

(FAS), etc., components. Use standard terminology.

If you filled in rectangles under **TART**, you do not need to write anything here for coding purposes; however, this section is useful for recording notes for personal use.

OMT: Fill in the Yes rectangle for each region in which an examination was performed and Osteopathic Manipulative Treatment (OMT) was given. Fill in the No rectangle if OMT was not performed on a region that was examined. Note: For each region treated, there must be boxes for Exam Method Used and Severity (1, 2, or 3) filled in for that region of the body examined on the Musculoskeletal Table (found on page 2 of 2).

Treatment Method: Listed here are the abbreviations of osteopathic manipulative treatment modalities, approved by the profession and included in the Glossary of Osteopathic Terminology, for treatment of the somatic dysfunctions listed previously. Circle the abbreviation that correspond to the modalities used to treat each region.

ART: articulatory treatment

BLT: balanced ligamentous tension /

ligamentous articular strain

treatment

CR: cranial treatment / osteopathy in the

cranial field / cranial osteopathy

CS: counterstrain treatment

DIR: direct treatment

FPR: facilitated positional release

treatment

HVLA: high velocity/low amplitude

treatment (thrust treatment)

IND: indirect treatment

INR: integrated neuromuscular release

LAS: ligamentous articular strain /

balanced ligamentous tension

treatment

ME: muscle energy treatmentMFR: mvofascial release treatment

ST: soft tissue treatment

VIS: visceral manipulative treatment

Response: Fill in one of these rectangles for each region of somatic dysfunction that was treated with OMT. This is the physician's perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment

<u>immediately</u> after treatment. The rectangles are indicated as follows:

- **R:** The somatic dysfunction is completely <u>Resolved</u> without evidence of it ever having been present.
- **I:** The somatic dysfunction is <u>Improved</u> but not completely resolved.
- **U:** The somatic dysfunction is <u>Unchanged</u> or the same after treatment as it was before treatment.
- **W:** The somatic dysfunction is <u>Worse</u> or aggravated immediately after treatment.

Physician's Evaluation of Patient Prior to

Treatment: This is the physician's overall opinion of how well the patient is doing based on objective findings of the patient prior to treatment as compared to the previous visit(s):

First visit: If this is the patient's first visit for a particular problem, mark the rectangle after **First visit.**

Resolved: If the problem for which a follow-up visit was requested is resolved, mark the b rectangle after **R**esolved. Example: If a patient presents for a follow-up on a musculoskeletal problem, filling in the **Resolved** rectangle implies that the region of the previous somatic dysfunction was evaluated, with no abnormal findings being found, and that you also filled in the **0** (zero) rectangle in the severity column for that region in the Musculoskeletal Table.

Improved: If the problem for which a follow-up visit was requested is improved, but not totally resolved, mark the rectangle after **Improved**.

Unchanged: If the problem for which a follow-up visit was requested is no different or completely unchanged from the prior visit, mark the **Unchanged** rectangle. This implies that, for a musculoskeletal problem, the general severity of the overall somatic findings is similar to that at the last visit. This may also apply if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.

Worse: If the problem for which a follow-up visit was requested is worse than it was at the last visit, mark the rectangle after **Worse**. This could occur with a musculoskeletal problem if no treatment was started at the prior visit, the

patient did something to aggravate their condition, or the patient had a complication or side effect of treatment given at the last visit. This refers to the patient's condition at the current visit. This does not reflect whether the patient had an early delayed response, i.e., a flare-up from the last treatment. Flare-up information can be charted in the Subjective section of these forms (found on page 1 of 2).

Section III: "A" Assessment

A: for the Assessment part of the SOAP note

Dx No. (diagnosis number): Write in your priority numbers in the **Dx No.** columns, with "1" being the number of the patient's most severe or addressed diagnosis at this visit.

Written Diagnosis: Write on this line the description for each of your ICD codes, if not already listed.

ICD Code: Write on this line the ICD code that corresponds to your diagnosis, if it has not already been written in.

Note: Somatic dysfunction written diagnoses and ICD codes have been written in for convenience. Only the diagnosis priority number needs to be added if needed.

Section IV: "P" Plan

P: for the Plan part of the SOA**P** note.

Meds: List in this space any medications issues that were addressed or new medications that will be started as a result of this visit. Dosage, route, administration, risks, benefits, and potential side effects can be listed here.

Exercise: List in this space any exercises you wish the patient to continue or add to their treatment prescription and whether they were discussed, taught, or given as handouts.

Nutrition: List in this space any nutritional, food, or diet recommendations that you have given or will give your patient.

PT: List in this space any Physical Therapy modalities your patient currently receives, has

received in the office, or that you recommend they receive or do.

Other: List in this space anything that does not fit into any of the other categories. For example, counseling could be addressed in this section. If 50% or more of your time spent with the patient was spent in counseling or educating the patient, specifically list the topics discussed, the details that were included, the handouts or educational materials given, and what referrals were made.

Minutes Spent With the Patient: Blacken the rectangle that corresponds to the amount of time you spent face-to-face with the patient and/or family during their visit (10, 15, 25, 40, 60, >60 minutes). This corresponds to the time allotments in the CPT book. Choose the box that best fits your total time.

Follow-up & Units: Blacken the rectangle that correspond to when you would like to see the patient again; you must indicate both the number and the Units. For example: for a visit in one month, blacken the box above the "1" and also the rectangle above "M" (month). Units abbreviations are as follow: D (days), W (week), M (month) Y (year), and PRN (as needed).

<u>Section V: Determination of Coding for</u> Evaluation and Management

Complexity / Assessment / Plan (Scoring): Only two of the following three categories (Problems, Risk, Data) are required for an established visit. Note that there are five levels and four rectangles below the list for each category. Add up the total points earned from each category. Record the total for each category by blackening the appropriate rectangle under one of the four levels. The total level for complexity is the average of the included areas (Problems, Risk, and Data).

Problems: Find which criteria match this visit.

This could be Self-limiting, Established problem—improved /stable, Established—worsening, New—no workup, or New—additional workup. Add points or number of problems that fit this patient in each category. Find level of problems by placing the total points under one of the four levels and blacken the appropriate rectangle.

Risk: Find which criteria match this visit. This could be **Minimal**, **Low**, **Moderate**, or **High** based on presenting problems, diagnostic procedures, and management options. Find the **level** of risk under one of the four levels and blacken the appropriate rectangle. OMT is low risk (level III).

Data: Find which criteria match this visit. This could be Lab, Radiology, Medicine, Discuss with performing physician, Obtain records or Hx from others, Review records, discuss with physician, or Visualization of tracing, specimen. Find the level of data by placing the total points under one of the four levels and blacken the appropriate rectangle.

Traditional Method—Coding by Components:

For each **History, Examination,** and **Complexity / Assessment / Plan** section, put a circle around the appropriate composite level. Then blacken the rectangle in the **Final Level of Service** that denotes the average of the three categories recorded.

Optional Method—Coding by Time:

When the majority of the Encounter (50% or greater) is counseling / coordinating, the Final Level of Service is determined by total time spent with the patient. Blacken the appropriate rectangle that indicates the total time of the visit: New patients (minutes)—10, 20, 30, 45, 60; Established patients (minutes)—10, 15, 25, 40. Be sure in your plan to write a brief description of topics discussed. (Also be sure to blacken the appropriate rectangle that corresponds to the total time spent with the patient.)

Section VI: Final E/M and CPT Coding

OMT performed as above: Fill in the rectangle for the number of regions with somatic dysfunction that were treated. Note: This number should correlate with the number of **Y**es boxes in the OMT section, and the number of boxes in the severity section marked with a 1, 2, or 3 of the musculoskeletal table on this page. The rectangles are defined as follows:

areas: You treated NO (zero) regions of somatic dysfunction with Osteopathic Manipulative Treatment.

- **1-2 areas:** You treated one to two regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- **3-4 areas:** You treated three to four regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- **5-6 areas:** You treated five to six regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- **7-8 areas:** You treated seven to eight regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- **9-10 areas:** You treated nine to ten regions of somatic dysfunction with Osteopathic Manipulative Treatment.

Other Procedures Performed: In the spaces provided, write in the **CPT Codes** and written

- diagnosis (**Written Dx**) for each procedure performed, other than OMT.
- E/M Code: Blacken the rectangle that corresponds to the evaluation and management code for your final level of service. For a new patient visit (New) use 99202, 99203, 99204, 99205. For an established patient visit (EST) use 99211, 99212, 99213, 99214, 99215. For a consultation visit (Consults) use 99241, 99242, 99243, 99244, 99245.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

D: \Sleszynski \ SOAP Note—Follow-up Usage Form Version 2:011403bw

Outpatient Os	teopathic SO	OAP Note—	Follow-up	p Form	l		wak SOAP Foll	ow-up version 2:011403
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Outpatient Osteopathic SOAP Note—Follow-up Form wak SOAP Follow-up version 2:011403b Patient's Name ___ Date ____ Sex: Male

Female Office of: Ht. * Vital Signs (3 of 7) For office Reg. Pt. position for recording BP use only: Pulse Standing Sitting Lying Irreg. **Patient's Pain Analog Scale:** ■ Not done NO PAIN WORST POSSIBLE PAIN CC: HPI: (Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated Signs and Sx) **PFSH: ROS:** (Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic) Level: HPI Meds: 4+ HPI Level ROS Level of PFSH Overall History = Average of HPI, ROS or PFSH: II (1-3 HPI) II (1-3 HPI, 1 ROS) IV (4+ HPI, 2-9 ROS, 1 PFSH) V (4+ HPI, 10+ ROS, 2+ PFSH) <u>O</u> Level of GMS

	II	1-5 elements
	Ш	6 + elements
	IV	2 + from each of 6 areas OR 12 + elements in 2 + areas
	v	2 + elements from each of 9 areas

Signature of transcriber: _____ Signature of examiner: _____

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	_	or timee	icveis	equais IIII						Dict	ate total ti	me and coun	seling /	/ coordinat	ting time	e plus a b	rief descripti	on of top	ics discusse	ed				
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Signature of transcriber: Signature of examiner:

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