

Expert Opinion

Evaluation and Management and Current Procedural Terminology Coding for Headache

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Evaluation and management (E/M) and current procedural terminology (CPT) coding are topics most of us would prefer not to discuss or read about but are crucial for the practice of medicine in the United States.

CLINICAL HISTORIES

Case 1.—A 39-year-old woman was referred by her family physician for a fifth neurological opinion with a chief complaint of a 15-year history of migraine without aura with increasing frequency that has become daily for the last 4 years. Extensive medical records are reviewed. She has failed numerous preventive and symptomatic medications. She is on daily combination analgesics and a triptan a few times a week, fluoxetine, and propranolol but still reports rather constant generalized pressure and throbbing headaches with an intensity ranging from 5/10 to 10/10 (actually she says a 20 even when the scale is explained) with intermittent nausea, light and noise sensitivity, and occasional vomiting but no aura. Past medical history of depression, anxiety, and fibromyalgia. Family history of mother

and sister with migraine. Neurological exam is normal. Treatment options are discussed.

Case 2.—A 28-year-old woman has a 5-year history of migraine with and without aura is seen for follow-up 5 weeks after the initial consultation. The migraines were initially 8 times monthly. She has been started on prevention with topiramate, which is causing paresthesias. The headaches have occurred 5 times in the last 1 month and go away within 2 hours within taking an oral triptan without side effects. Her headache diary is reviewed. She is counseled that the paresthesias will probably resolve with time and that she could try bananas or orange juice to alleviate the symptoms. She will continue the same medications and return in 2 months.

Questions:—Under Medicare rules, how is a consultation defined? Would Case 1 be a consultation? What E/M code would be appropriate for Case 1? What CPT code is used for migraine, chronic migraine, and migraine with medication overuse headache? What E/M code would be appropriate for Case 2?

EXPERT OPINION

Identifying the proper E/M code for both cases exemplifies the traditional paradigm of documenting the physician's care then trying to identify the code for

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the level of service provided. To properly define E/M services, there are 7 components recognized: history, examination, medical decision making (MDM), nature of the presenting problem (NPP), counseling, coordination of care, and time. The first 3 components, history, examination, and medical decision making, are recognized as the key components of E/M services. Each of the 3 key components is further divided into 4 categories. The history includes: CC, HPI, PFSH, and ROS. The 4 levels of the physical examination are: problem focused, expanded problem focused, detailed, and comprehensive. The 4 elements of medical decision making include: straight forward, low complexity, moderate complexity, and high complexity.¹ Our education in medical school trained us how to obtain an insightful history and perform a thorough physical examination. The comprehensive H/P we were taught has provided the highest quality of medical care but does not fulfill the requirements of the multiple medical record components that are required by CPT coding system for E/M coding. In addition, the low conversion factor for the resource based relative value system (RBRVS) often translates into reimbursements by both Medicare and private insurers that are not cost effective. To be more efficient and improve reimbursements, physicians must have a better understanding of the CPT requirements.

Some of the terminology in the CPT guidelines parallel the traditional medical nomenclature but the level of care is determined by the documentation of the specific elements required to meet E/M coding. This includes recording the H/P in a way, which will help the physician (or auditor) identify the level of E/M care. It also includes documenting nontraditional medical terms required by the CPT coding system. These include the components of MDM: nature of the presenting problem, the 3 elements of risk, and the complexity of data.

Obtaining the medical history does follow traditional medical nomenclature, but documentation guidelines are specific for E/M coding and determination of level of care.

The extent of HPI, ROS, and PFSH that is obtained and documented “. . . is depended upon clinical judgment and the nature of the presenting problem(s).”² The number of elements described will de-

termine the level of service for the history. The traditional physical examination, if not properly recorded, may not satisfy the CPT coding requirements for the higher levels of E/M coding for many of our complicated headache patients. On the positive side, the 1997 edition of *Documentation Guidelines* defined not only a general multi-system examination, but also 11 single organ system examination templates including the neurological examination.³ Each body area or organ system is identified by bullets or elements. The number of bullets helps define the level of examination. At the initial visit, most of our headache patients will require the neurological single system examination (SSE), which consists of 25 elements or bullets. Between 23 and 25 bullets are required for a comprehensive SSE.

The nature of the presenting problem (NPP), which is “. . . a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter,”⁴ is defined in terms of risk. This includes the risk of morbidity and mortality, risk of comorbidities and risk of complications or prolonged functional impairment. The nature of the presenting problem helps identify the appropriate level of care during the physical examination, but is also a major element when documenting the third key component of the E/M coding system, medical decision making. The importance of the NPP is even more obvious when discussing the Table of Risk, which is principal in defining the third component of MDM.

Medical decision making is the most complex of the tasks and the biggest challenge in deciding the correct billing code. The MDM is determined by integrating information from the 3 categories of: 1) number of diagnoses or management options, 2) amount and/or complexity of data to be reviewed, 3) risk of complications and/or morbidity or mortality. The grading of each category is as follows: minimal, limited, moderate, and extensive for the number of diagnosis or management options. Although there is no number set in the CPT guidelines for diagnosis or management options, “extensive” suggests a quantitative interpretation of “the more the better.” The grading for the categories 2) amount of data reviewed/ordered and 3) risk of disease and

Table.— Table of Risk

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

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procedures/Rx. is minimal, low, moderate, and high. Since the element of “risk” is such an important component of the MDM, it is surprising that the Table of Risk, published in the 1997 *Documentation Guidelines*, is not more familiar to physicians and other health-care providers. The Table of Risk provides examples of health problems within the following 3

categories of risk: 1) risk of the presenting problem(s), 2) risk of diagnostic procedure(s) ordered, 3) risk of management options selected.⁵ The highest level of risk in any one category determines the overall risk. It is important to emphasize that for complex headache patients, the overall risk of the presenting problem as well as the risk of management options

selected may often meet the criteria for coding at the highest level. With proper documentation, the CPT code for a first encounter may be at the 99205 or 99245 level.

In most circumstances, time spent with the patient is generally not included in E/M code calculations. However, the CPT coding system and the *Documentation Guidelines for Evaluation and Management Services* permits time to be considered the *sole* determining factor for E/M code selection. This must be face-to-face time spent in counseling and coordination of care of the patient. "In the case where counseling and/or coordination of care dominates...the physician/patient and/or family encounter...time is considered the key or controlling factor to qualify for a particular level of E/M services." If the level of service is based on counseling and/or coordination of care, "...the total length of the face-to-face encounter should be documented and the record should describe the counseling and/or activities to coordinate care."⁶

Specialists should not bill for a "consultation" (CPT codes 99244–99245) when a transfer of care occurs. The revised *Medicare Claims Processing Manual*, effective January 1, 06, listed "clarifications" in Medicare rules in distinguishing a consultation vs. a New Patient Referral (CPT codes 99201–99205).⁷ The latter generally pays a lower fee. The transfer of care occurs when the physician requests another doctor to assume the responsibility for managing the patient's complete care for the condition. In most cases, a consultation is a one-time visit. There has been some confusion over Medicare rules, which also indicate that the requesting physician and consulting physician must both document, in the patient's medical record, the request and the reason for the consultation. The concern has been that without both documentations, the consulting physician will not be paid or may be "down coded" when submitting a 99244–99245 code. However, as stated in a recent American Academy of Neurology newsletter, the consulting physician is not required to confirm that the requesting physician documented the request. The guidelines state, "if referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested."⁸ Each physician is required to individu-

ally keep accurate records and code accordingly. In the revised *Medicare Claims Processing Manual*, the section which discusses consultation followed by treatment, there are also rules governing those occasions when it may be necessary for the consulting physician to assume ongoing care of the patient. It should be emphasized that the above guidelines differentiating a consultation from a New Patient Referral apply primarily to Medicare patients. Currently it appears that non-Medicare payers have not yet implemented these regulations.

Case 1.—This individual was a complicated headache patient who required a comprehensive H/P and probable comprehensive SSE (23 to 25 bullets). The number of diagnosis and management options, including her comorbid issues, meet criteria for extensive complexity. The data reviewed meets the criteria for extensive. Using the Table of Risk, the level of risk of the NPP is High: "One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment." Using the Table of Risk, the level of risk of management options is High: "Drug therapy requiring intense monitoring for toxicity."⁹ Therefore, it is my opinion that the combination of a comprehensive history, a comprehensive examination, and medical decision making of a high complexity would meet criteria for a 99245 code. The level of care would be a consultation (99245) and not a referral for evaluation and management (99205), because there is no mention of transfer of care. The ICD-9-CM codes that I would use are: 346.01 and 346.81. There is no specific ICD-9-CM code for the diagnosis of chronic daily migraine or medication overuse headache. However, in personal communication with the American Academy of Neurology Medical Economics Department, there appeared to be agreement among those expert physicians contacted that 346.81 would be the best code to use for this diagnosis.¹⁰

Case 2.—It appears this individual was an established patient in whom greater than 50% of the time was spent in face-to-face counseling and coordinating care. The visit included a review of her headache diary, risks and benefits of treatment options, review of the benefits of abortive care, review of managing side effects of prophylactic care, and instructions for treatment and follow-up. Although time spent is not

usually a factor in E/M coding, the CPT codebook lists “average times” associated with each CPT code to “assist physicians in selecting the most appropriate level of E/M services.”¹¹ For an established patient 99214 is 25 minutes; 99215 is 40 minutes. If the above criteria were met, I would use the 99214 for the level of care. The ICD-9-CM code I would use would be 346.01; migraine w/aura with intractable pain. One could argue that her condition is not “intractable.” The Webster’s College Dictionary defines intractable as “. . .hard to treat, relieve, or cure.”¹² I believe this patient meets those criteria. She has consulted a headache specialist because of the severity of her problem, has recurrent migraine with aura, had migraine up to 8 times monthly, uses triptans for abortive care, is on a prophylactic medication for prevention, and is now demonstrating side effects secondary to treatment.

Since the initial publication of the 1992 edition of the American Medical Association’s CPT codebook, there have been endless publications and volumes of books written on the E/M coding system as presented in the CPT codebook and the *Documentation Guidelines for Evaluation and Management Services*. For physicians practicing medicine in the real world, it is often extremely difficult to be compliant with the various rules while caring for multiple patients throughout the day. Also, the conventional medical record does not satisfy the new requirements. By better understanding the E/M coding system and rules published in the CPT codebook, it is the physician’s challenge to meet the demands of a complex health-care system while still providing excellent patient care. The quality care of our patients is still our central theme and the reason why we became physicians.

Conflict of Interest: None declared

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