AHS's Headache Coding Corner

- **A user-friendly guide to CPT and ICD coding**

Stuart Black, MD

Part 1—General Issues in Evaluation and Management (E&M) in Headache

By better understanding the Evaluation and Management (E/M) coding system and rules, it is the physician's challenge to meet the demands of a complex health care system while still providing excellent patient care. While physicians are faced with multiple challenges to meet these demands, quality care of our patients is still the central theme and the reason why we became physicians. A working knowledge of the E/M methodology unites the goal of quality patient care and conformity to the Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) regulations. A thorough understanding of the CPT coding system is essential in order to provide accurate reporting of medical services and procedures and to correctly describe medical, surgical, and diagnostic services among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. Accurate ICD codes provide The Centers for Medicare and Medicaid Services (CMS) and other third – party insurance carriers correct and complete coding to the third, fourth, or fifth digit.

In this series posted on the American Headache Society website, the CPT coding fundamentals and ICD coding recommendations for headache patients will be reviewed. New sections will be posted quarterly. This initial segment will focus on some general and important issues regarding CPT coding.

Identifying the proper CPT code exemplifies the traditional paradigm of documenting the physician's care then trying to identify the code for the level of service provided. To help insure more accurate coding, there are some key points regarding the CPT coding system which are worth reviewing. When the AMA first developed and published the CPT nomenclature in 1966, a four – digit system was used. The second CPT edition published in 1970 presented an expanded system of terms and codes to designate diagnostic and therapeutic procedures. It was at that time that the five – digit codes were introduced. Currently, all CPT codes are five digit codes. CPT codes are revised and updated annually by the AMA and the revisions become effective each January 1st. Since hundreds of CPT codes are added, changed, or deleted each year, it is important for all health care professionals to maintain copies of the current code books. The CPT coding system includes thousands of codes and definitions for medical services, procedures and diagnostic tests. Category 1 CPT codes describe a procedure or service identified with a five – digit numeric CPT code and descriptor nomenclature. These codes are based on the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Category 1 CPT codes are restricted to clinically recognized and generally accepted services, not emerging technologies, services, and procedures. All of the E/M codes are included in Category 1. Two additional CPT code categories debuted in 2002. Category 11 CPT codes are a set of **optional** codes developed principally to support performance measurement. These codes are intended to facilitate data collection, do not have a relative value associated with them, and are not required for correct E/M coding. Category 11 codes have been developed for following the care and good outcomes in certain clinical conditions such as: asthma, chronic stable coronary artery

disease, congestive heart failure, hypertension, osteoarthritis, prenatal care and preventive care. There are also Category 111 CPT codes which are **temporary** codes used for emerging technology, services and procedures. These codes may be covered by given carriers if prearranged but are not covered by Medicare.

The Evaluation and Management codes (99201 – 99499) are used by most physicians in reporting a significant portion of their services and are divided into broad categories such as office visits, hospital visits, new patient encounters and consultations. Most of these categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). To properly define the E/M services, there are seven components recognized: History, Examination, Medical Decision Making (MDM), Nature of the Presenting Problem (NPP), Counseling, Coordination of Care, and Time. The first three components, History, Examination and Medical Decision Making are recognized as the key components of E/M services. Each of the three key components is further divided into four categories. The History includes: CC, HPI, PFSH and ROS. The four levels of the Physical Examination are: Problem Focused, Expanded Problem Focused, Detailed and Comprehensive. The four elements of Medical Decision Making include: Straight Forward, Low Complexity, Moderate Complexity and High Complexity. By year end, it is the intent for this part of the AHS website to have thoroughly reviewed the CPT (and ICD) coding system as it applies to the care of the headache patient. This current AHS website segment will focus on *Identifying the Correct Type of CPT Service for Each Visit.*

To a large extent physicians use about four or five different types of service codes for the majority of care they provide. The most frequently used outpatient visit CPT codes are:

Initial visits:	CPT codes 99201 - 99205
Established patient visits:	CPT codes 99211 - 99215
Office consultations, new or established patients:	CPT codes 99241 - 99245

The most commonly used hospital care codes are:

Initial hospital care:	CPT codes 99221 - 99223
Subsequent hospital care:	CPT codes 99231 - 99233
Inpatient consultations, new or established patients:	CPT codes 99251 – 99255

Medical services are characterized by face – to – face services for the purposes of classifying new and established patients. A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years. An established patient is one who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years. The CPT definitions do not explicitly address the question of cross referral to a subspecialist within a given group. For example, if a headache specialist, whose practice is exclusively limited to the care of headache patients, practices with a group of neurologists who are not headache specialists, is it possible for a patient, who may be referred to the headache subspecialist within the same group, to be considered a new patient. The answer is yes but it would be best if the headache subspecialist had a separate tax identification number for their subspecialty. Since the question of

subspecialty reporting within a given specialty is not precisely addressed in CPT definitions, this type of cross referral would be open to interpretation.

It is also important to understand the difference between a new patient Consultation and a New Patient Referral. The need for a physician to request advice or expert opinion from a colleague, in the form of a professional consultation, is almost as old as medicine itself. However, physicians must be aware that there have been **"clarifications"** in the CPT guidelines distinguishing a Consultation (99241 – 99245), versus a New Patient Referral (99201 – 99205). For purposes of CPT, a consultation is defined as a type of service provided by a physician whose opinion or advice regarding evaluation and / or management of a specific problem is requested by another physician or other appropriate source. It appears there had been confusion in reporting consultative services beginning with the terms used to describe the service requested. The terms *consultation* and *referral* were mistakenly interchanged. When a physician refers a patient to another physician, it is not automatically a consultation. The revised Medicare Claims Processing Manual, effective Jan 1, 06, listed clarifications in Medicare rules in distinguishing a Consultation verses a New Patient Referral. The latter generally pays a lower fee. Historically, physicians have known that in reporting a consultation service, the three R's must be documented: *Request, Render, and Report.* Starting in 2006, CPT requirements have included one more R requirement: a *Reason.* There must be a request for consulting services from another physician or health care provider, the suspected or known diagnosis requires determination by a specialist who renders his / her opinion, the referring physician and consultant specifies a reason for the consultation, the treatment is undetermined or may be known, and a written report to the requesting physician or referring source reiterating the reason for consultation plus the findings and opinions must be forwarded by the consultant. In most cases, a consultation is a one – time visit. A New Patient Referral usually has an identified problem which requires a specialist to provide care, and does not require that a written report be sent to the requesting physician or health care provider.

The policy changes or clarifications also state that a transfer of care occurs when a physician requests another doctor to assume the care of the patient. Ongoing management of the patient by the consultant physician cannot be reported using a consultation service code. Therefore, a referral for evaluation and management (E/M) cannot be considered a consultation because there has been a transfer of care. There also has been concern regarding language that the consulting physician must document the request and reason for the consultation in the patient's medical record. Without that documentation, the CPT code for a consultation could not be use. However, according the the E/M documentation guidelines, the consulting physician is not required to confirm that the requesting physician document his / her request. The documentation criteria for a consultation service requires that the requesting physician and consulting physician both document the request for consultation in their medical records, but each physician is required to keep their own 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.

When a patient is seen as a consultation or new referral, all three of the key components, History, Examination, and Medical Decision Making, must be reported and meet or exceed the stated requirements to qualify for a particular level of EM service. When an established patient (seen within the past three years) visit is reported, two of the three key components must meet or exceed the stated requirements to qualify for a particular level of E/M service. Although time is not taken into account as a factor for determining the level of E/M care during most patient visits, the CPT codebook includes the inclusion of time as an explicit factor to assist physicians in selecting the most appropriate level of service. The CPT codebook and the *Documentation Guidelines for Evaluation and Management Services* do define specific circumstances which permits time to be the sole determining factor in E/M selection. When counseling and / or coordination of care comprises more than 50% of the time spent during an encounter, then time may be considered the key or controlling factor to qualify for a particular level of E/M service. This must be "face – to face" time with the patient or the family and may be unit / floor time when in the hospital. The latter includes the time in which the physician establishes and / or reviews the patient's chart, examines the patient, writes notes, and communicates with other professionals and the patient's family. This means that the amount of time spent in patient care is permitted to become the sole determining factor of the level of E/M service even if the physician did not perform or report any of the three key components. The physician must document the total length of time of the encounter plus a description of the counseling and / or activities involved in the coordination of care. The record documentation must also state that more than 50% of the encounter was involved in counseling and / or coordination of care. When the physician defines that more than 50% of the visit time was dedicated to counseling and coordination of care, the E/M code can be determined by the time values that are listed in the CPT codebook for each type of E/M service and each level of care. The CPT codebook also points out that the specific times expressed in the visit code descriptors are averages, and represent a range of times that may be higher or lower depending on the actual clinical situation. In the management of headache patients, office visits are often spent in counseling and coordination of care. Physicians treating headache patients should consider using the amount of time and effort spent performing this service as a determining factor in defining any particular office or hospital visit.

As stated above, an important guideline to remember when reporting office visits other than counseling and coordination of care is that only two of the three key components must be reported. The following is a summary of the requirements for codes 99211 – 99215.

99211: 5 minutes and may not require the presence of a physician
99212: 10 minutes
A problem focused history
A problem focused examination
Straight forward decision making
99213: 15 minutes
An expanded problem focused history
An expanded problem focused examination
Medical decision making of low complexity
99214: 25 minutes
A detailed history
A detailed examination
Medical decision making of moderate complexity

99215: 40 minutes
A comprehensive history
A comprehensive examination
Medical decision making of high complexity

History and physical examination skills and documentation guidelines we were taught in medical training tend to produce a very high quality of medical care. But these do not always meet the guidelines in the multiple medical record components that are required by CPT coding system for E/M coding. To be more efficient and improve reimbursements, physicians must have a better understanding of the Current Procedural Terminology requirements. Future discussions in this section of the AHS website will include a comprehensive discussion of the three key components of CPT coding: History, Examination, and Medical Decision Making, as well as a review of the importance of understanding the Nature of the Presenting Problem in ensuring proper coding. The fourth quarterly future topic in this series will be devoted to the International Classification of Diseases (ICD – 9-CM) coding.