AHS's Headache Coding Corner

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

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Part 2—H&P and Nature of the Presenting Problem (NPP) in Headache Coding

In traditional medical training we are taught the history and examination skills which are essential for high quality medical care. However, traditional medical education does not always define new CPT nomenclature such as the "nature of the presenting problem" (NPP) nor do we learn the extensive list of coding rules we are expected to follow to be compliant with CPT guidelines. Many of us had been taught how to perform the histories and physicals and how to document the medical record using guidelines that pre–date the introduction of Evaluation and Management (E/M) coding and the Documentation Guidelines. As an example, a conventional approach to defining the appropriate E/M code is to finish the medical encounter and then secondarily attempt to calculate the proper E/M code. In reality, this often does not work well. Often the information necessary for documentation had not been recorded, the time needed to perform mathematical calculations is not available, or there are insufficient medical record tools to facilitate compliant documentation. With the use of electronic medical records, and the tools that accompany them, physicians and other health care providers now have the opportunity to develop a medical record which is more efficient in E/M coding methodology. The goal is to maintain our dedication and commitment to excellent patient care and to make sure our documentation is compliant with E/M coding requirements. To achieve this goal we must better understand the new E/M terminology and requirements.

The nature of the presenting problem (NPP) is not a term found in traditional medical training. Similarly, the NPP has not been defined as one of the "key" components (history, physical examination, and MDM) of E/M but received the status of a "contributory factor." However, the NPP is the reason for the medical encounter and is important in identifying the level of care. The NPP is defined in the CPT manual as follows:

"A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter, with or without a diagnosis being established at the time of the encounter."

Therefore, the NPP should become identifiable after the physician completes the history and begins to formulate the differential diagnosis. When one reviews the details of CPT coding, it is apparent that the NPP is important in coordinating coding and documentation with medical necessity. The CPT manual describes five levels of the severity of the NPP:

Minimal
Minor or self–limited
Low
Moderate
High

It is important to recognize that in descriptions of the degree of severity, the determining factor is defined according to the natural history of a medical problem if that problem is left untreated. This includes the risks of the condition; specifically morbidity, mortality and functional impairment. The risks are defined in the CPT codebook and dictate the level of severity. In addition, the NPP becomes important when defining the level of care in medical decision

making (MDM). The “Table of Risk” includes the NPP as one of the three components of defining risk; “The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options”. The “Table of Risk”, which incorporates common clinical examples rather than absolute measures of risk, will be discussed in more detail in the next segment on MDM.

Documentation of the NPP also records the medical necessity for the visit. Following completion of the history and after choosing one of the five levels of the presenting problems (NPP) as described in the CPT manual, there should be correlation in determination and documentation when it becomes time to define the level of risk in MDM. Obviously, once the NPP has been determined following completion of the history and formulation of a preliminary differential diagnosis, the NPP may be adjusted at any point during the patient encounter. By documenting the NPP during the initial part of the H&P and then latter at the time of MDM, there should be an integration of care. The final level of CPT code should reflect the effort put forth by the physician in defining and treating the patient’s problem.

A number of headache patients referred to a neurologist and/or headache specialist for diagnosis and treatment have a condition where the risk of morbidity without treatment is moderate to high. One might conclude that is the reason for referral or consultation. Examples of conditions we commonly see for evaluation include individuals who have chronic daily migraine with/without medication overuse or patients who are incapacitated with frequent episodic migraine that has been unresponsive to conventional abortive or prophylactic medications. Essentially, any headache patient who has the probability of experiencing significant functional impairment as a result of their illness warrants a level 5 care. Without appropriate treatment, the dysfunction and/or disability secondary to the condition is often associated with increased or a high probability of a severe decline in the patient’s quality of life. Epidemiology studies of migraine have documented the significant impairment and impact migraine has on our population. The medications used for treatment require monitoring for therapeutic benefit as well as side effects or “toxicity”. Therefore, if the NPP is properly defined and recorded, the treatment of many migraine patients does meet the criteria for high to moderate severity and warrants a level 5 or at least a level 4 care. The same criteria would apply to established patient visits. Obviously, there are other headache/migraine patients who are less likely to suffer the more serious consequences. Those individuals might warrant a level 3 or 4 care.

Many of us who have been practicing medicine for a number of years were taught and still believe that obtaining a good medical history will often result in an accurate diagnosis even before picking up a stethoscope. There are no diagnostic tests to define migraine or the dysfunction/disability associated with migraine. An accurate history will often define an effective differential diagnosis which may indeed lead to appropriate investigation and/or tests to more precisely define the nature of the patient’s medical problem; to help define the NPP. Although the comprehensive H&P we were taught provides excellent insight into the diagnosis and treatment of our patients, it may be noncompliant with the CPT E/M coding system.

For E/M coding, the elements of the history do include the traditional information taught in medical school; the chief complaint (CC), history of present illness (HPI), review of systems (ROS), and past, family, and social history (PFSH). For coding purposes, history must always include the CC. However, the completeness of the other three components of the history is what determines the overall coding level of the history. The descriptions of E/M services recognize four levels of history:

Problem-focused
Expanded problem-focused
Detailed
Comprehensive

The Documentation Guidelines defines the progression of the elements required for each type of history. The Guidelines also state that "the extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s)."

The CPT guidelines recognize eight dimensions of the HPI, This includes:

Location
Quality
Severity
Duration
Timing
Context
Modifying factors
Associated signs and symptoms

The descriptions of these components may be found in more comprehensive references on E/M coding. The Documentation Guidelines indicate that "a brief HPI consists of one to three elements of the HPI,' and "an extended HPI consists of at least three chronic or inactive conditions." The medical record should describe the appropriate number of elements of the HPI. It should be emphasized that the HPI does give the physician an opportunity and freedom to describe and narrate each headache patient's clinical situation. For more complex headache patients, accurate documentation would justify a Detailed or Comprehensive level of care.

The past, family, and social history (PFSH) and the review of systems (ROS) are obtained at the initial patient encounter. The Documentation Guidelines for Evaluation and Management Services states "A ROS and/or a PFSH obtained during an earlier encounter does not need to be re – recorded if there is evidence that the physician reviewed and updated the previous information" To ease documentation, it is not mandated that the physician be the data entry person for this section of medical information. An assistant can obtain this information from the patient or the PFSH and ROS can be completed by the patient and acknowledged, signed and dated by the physician. The ROS consists of fourteen categories ranging from constitutional through psychiatric. The following elements of a system review have been identified in the CPT code set:

Constitutional (fever, weight loss, etc.)
Eyes
Ears, nose, mouth, throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Integumentary (skin and/or breast)
Neurologic
Psychiatric

Endocrine
Hematologic/Lymphatic
Allergic/Immunololgic

Most initial neurological evaluations for complex headache patients will require a complete PFSH and a complete ROS. If the examiner understands the definition of the NPP as described above, the documentation of the HPI and a complete PFSH and ROS will be sufficient to support whatever E/M code the NPP indicates. Of the four types of history recognized in E/M services (Problem focused, Expanded problem focused, Detailed, and Comprehensive), the assessment of a complex headache patient should warrant a Detailed or Comprehensive code. As emphasized earlier, for outpatient established visits, the documentation of the PFSH and ROS can be satisfied without again repeating the same process as performed at the initial visit or previous visits. The Documentation Guidelines state that these requirements may be met by "describing any new ROS and/or PFSH information or noting there has been no change in the information; and noting the date and location of the earlier ROS and /or PFSH."

The physical examination is also categorized as Problem focused, Expanded problem focused, Detailed and Comprehensive. The 1997 edition of the Documentation Guidelines defined twelve categories of Single System examinations (SSE). The Single System Neurological examination consists of 25 elements or bullets. They are categorized as follows:

• General appearance of the patient	1 point
• Measurement of any 3 of 7 vital signs	1 point
• Ophthalmologic examination	1 point
• Cardiovascular examination	
-Examination of carotid arteries	1 point
-Auscultation of heart	1 point
-Examination of peripheral vascular system	1 point
• Higher cortical functions	5 points possible
• Cranial nerves	8 points possible
• Sensation	1 point
• Muscle strength	1 point
• Muscle tone	1 point
• Deep tendon reflexes	1 point
• Coordination	1 point
• Gait and station	1 point

A Comprehensive level of examination requires the examiner perform and document twenty three points or bullets (under Cardiovascular, at least one element must be examined). A Detailed examination requires twelve to twenty two points. An Expanded focus examination requires six to eleven points. A Problem focused examination requires one to five points or bullets. One comment must be documented for each cranial nerve to be counted as a bullet. Testing of cranial nerves 1 and 10 does not count for a bullet

Identifying and documenting the NPP is an indicator of the severity of the patient's illness. If the NPP is "high", as may be determined in the evaluation of a complex headache patient, a level 5 care would be warranted. After defining the appropriate level of care based on the history, formulation of the differential diagnosis and determination of the NNP, the physician should next further evaluate the remaining two "key" components of E/M. This would include the physical examination, and medical decision making (MDM). Once the level of NPP has been determined, it should serve as a guideline when evaluating the additional components of E/M.

Documentation of the H&P and MDM should confirm that the amount of care provided meets or exceeds the CPT requirements for the severity of the patient's NPP.

In this section of the AHS's Headache Coding Corner, we focused on the NPP and H&P guidelines. The next section in this series will review the third key component, medical decision making (MDM). The MDM includes nontraditional documentation categories which most of us were not taught in medical school. MDM documentation remains one of the greatest challenges for physicians attempting to achieve compliant E/M records and correct billing codes. The specific requirements and documentation of MDM will be defined in detail at the next segment of AHS's Headache Coding Corner.