Practical Approaches to Medical Necessity

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Objectives

- Understand how medical necessity is defined by payers and the impact on billing services.
- Understand the difference between medical necessity and medical decision making
- Learn practical application and compliance strategies to address identified risks
Office of Inspector General

- “Good documentation practice helps ensure that your patients receive appropriate care from you and other providers who may rely on your records for patients’ past medical histories.”

- Source: Fraud and Abuse Booklet

Medicare Defines Medical Necessity

- How often patient was seen for same problem and what was done during those visit.
- How many diagnoses? Acuity? Duration? Severity of problem(s) assessed
- Complexity of documented comorbidities that clearly influenced physician work.

https://www.cms.gov/Manuals/IOM/ItemDetail.asp?ItemID=CMS018912
Medical necessity is the “overarching criteria for payment in addition to the individual requirements of a CPT code.”

“The volume of documentation should not be the primary influence upon which a certain level of service is billed.

At audit, Medicare will deny or down code E/M services that, in its judgment, exceed the patient’s documented needs.

Medicare Claims processing manual Pub 100-4, Ch 12 30.6.1.A

First “nature of presenting problems”

The second medical necessity assistance in CPT is guidance found within Appendix C – Clinical Examples.
Payers In General

*Medical necessity is:*
1. In accordance with generally accepted standards of medical practice
2. Clinically appropriate
3. Convenience is not a factor

The Blind Men and The Elephant

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Physician’s Perspective

Does the documentation of the stability of chronic conditions describe the visit in the contextual progression of clinical disease states and physician clinical management of the patient?

Is the patient’s need for clinical services documented by the physician’s clinical documentation in the note?
Coder’s Perspective

- Is there an interval history?
- Patient status?
- ROS?
- Exam?
- Labs/diagnostic studies?
- Plans?

- Level of Service _____________

Payer’s Perspective

- Patient status?
- What are the exam findings?
- Any changes from previous visit?
- Is this the appropriate level of care?

- Level of Service: ________________
Difference

• What is the difference between medical necessity and medical decision making?

Medical Decision Making

• Number of diagnosis and management options

• Complexity of data

• Risk of M & M
Medical Necessity

- Amount of history and exam should be based on the nature of the presenting problem.

Physician Perspective

- New Problem?
- What is happening?
- What has changed?
- Any contributing factors?
- Any changes in other systems?
- Exam findings?
- What tests are needed?
- How critical is the situation?
Coder’s Perspective

- Is there a chief complaint?
- Is the ROS pertinent?
- What about PFSH?
- Was the level of exam appropriate for the nature of the presenting problem?
- What is plan and assessment?

Payer’s Perspective

- Nature of presenting problem
- Pertinent ROS
- Appropriate exam
- Frequency of visits
- Diagnostic Workup
- Plan
Clinical Example

CC:
Sore throat/nasal congestion /headache since 12/11/11.

HPI:
15 y/o female c/o of headache, no anosmia, greenish productive cough in am x 1 day. Pt states pain with inspiration. OTC- None. Pt states friends have been ill. One month ago had antibiotic.

ROS:
CONSTITUTIONAL:
no chills. no dysphasia, change in appetite –decreased. positive for fever and general malaise.
EARS:
ringing yes. no hearing loss. no discharge. no ear pain. Positive fore sensation of fullness.
NOSE:
no bleeding. no diffuse facial pain. no anosmia. no rhinorrhea. Positive for congestion and sneezing.
MOUTH AND THROAT:
no halitosis. Positive for difficulty swallowing. no tonsilar enlargement. Positive for post nasal drip.
NECK:
no pain. no stiffness. no swollen glands. no decreased range of motion.
RESPIRATORY:
productive cough, yellow. green sputum
GASTROENTEROLOGY:
positive for nausea .no vomiting. no diarrhea.
NEUROLOGY:
no vertigo. no weakness. no numbness. no incoordination. no tingling. Positive for headache.
Clinical Example

Medical History: none. Surgical History: PE tubes.

Family History: Non-Contributory as related to today's chief complaint.

Social History: Tobacco Use: no tobacco use, no exposure to secondhand smoke. Occupation: 9th grade student.

Medications: Strattera (ADHD Medication) 40 mg capsule 1 cap(s) once a day (in the morning), cetirizine 10 mg tablet 1 tab(s) once a day, Medication List reviewed and reconciled with the patient

Allergies: None.

Clinical Example

Objective: Vitals: Temp 99.7, Pulse 78, RR 18, BP 126/76, Pain (at time of visit) 5/10, LNMP a few days ago, Wt 122.

Examination:

GENERAL: no acute distress, well nourished and hydrated, appears well. HEAD: symmetrical facial features. EARS: right. ---EXTERNAL CANAL---. external canal w/o redness, swelling, discharge. ---TM---TM intact, pearly gray, landmarks visualized. fluid visualized behind TM. ---HEARING---. hears all normal conversational speech. ---TRAGUS---. non-tender, bilaterally. ---MASTOID TIP---. non-tender, bilaterally. left. external canal w/o redness, swelling, discharge. TM intact, pearly gray, landmarks visualized. NOSE external nose free of swelling, trauma, and deviation, no discharge, no septal deviation or perforation, mucosa dull red, smooth, moist, & free of inflammation. MOUTH AND THROAT: ---LIPS---. lips pink, moist. ---ORAL MUCOSA---. oral mucosa pink, moist, w/o lesions or discolorations. ---PHARYNX---. uvula midline. pharynx injected. ---TONSILS---. no tonsillar enlargement, no exudate. ---TEETH---. teeth in good repair. NECK: no lymphadenopathy, full range of motion. RESPIRATORY: breath sounds clear throughout, respiration even and unlabored. CARDIO: S1 & S2 single sounds, no murmurs, gallops, or clicks. RRR. NEURO: ---GAIT---. gait steady. ---ORIENTATION---. oriented to person, place, and time. ---JUDGMENT---. judgment intact. ---DERM---. no Rash

Assessment: 1. Pharyngitis (acute) - 462 (Primary) Plan: Start Salt Water Gargles, 1/2 water and table salt, as directed, orally, 3-4 times daily ; Start Motrin tablet, 600 mg, 1 tab(s), orally, 4 times a day, 30 day(s), 120.

LAB: Strep Screen-negative
Risks

- Electronic Health Records
  - Cut and Paste (Cloning)
  - Auto-Code
  - Volume of Documentation
- Salesmen
  - Equipment – U/S, NCS, Dopplers
  - Software
- Process itself
  - Balancing tensions

Risks

- Electronic Medical Record:
  - Use auto coder?
  - 1995 or 1997 guidelines?
  - Which 2 of 3 for established patients?
  - Scanning? What goes where?
- Naming template and one chosen does not reflect service
- CPT description in EMR is incorrect
- Authentication
- What auto-populates-verbiage such as “routine,” elements?
Practical Solutions

- Policies on all areas of EMR
- Education for staff and providers
- Audit, review, education, and monitor

Conclusion

- Understand medical necessity from payer, coding and physician perspectives.
- There is a difference between medical necessity and medical decision making
- Apply strategies to address identified risks.
Questions

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