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Meet the Presenter…

Shannon O. DeConda
CPC, CPC-I, CEMC, CMSCS, CPMA
President/Founder, NAMAS
Partner, DoctorsManagement, LLC

On the topic:
Medical Necessity of the Encounter
Agenda:
Connecting the medical necessity

First Piece
What is medical necessity, and how should it impact your day-to-day operations?

Second Piece
How do the carriers view medical necessity? How should your organization view medical necessity?

Third Piece
What’s next, and what do you do now?
What is medical necessity?

• How is medical necessity scored?
• Where are the guidelines for medical necessity?

Medical Necessity

So tell me, what is medical necessity?

“Medically Necessary” or “Medical Necessity” shall mean healthcare services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

  a) In accordance with the generally accepted standards of medical practice;
  b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
  c) Not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
Medical Necessity

• The Social Security Act, Section 1862 (a)(1)(A) states: "No payment will be made ... for items or services ... not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member." This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. For this reason, CMS validates E&M services not only on the amount of documentation and the elements being met within the documentation, but also on the medical necessity associated with a certain complexity of care involved with the patient.

Medical Necessity

• Medicare, in their broad definition of medical necessity states in an excerpt from the CMS Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1,

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

• While this offers great guidance, it stills lacks specificity and leaves auditors with varying opinions on how to abstract medical necessity.
Carrier Considerations

• CGS Medicare states: Identify all the presenting complaint(s) and/or reason(s) for the visit for which physician work occurred.
  • Demonstrate clearly the history, physical and extent of medical decision-making associated with each problem.
  • Demonstrate clearly how physician work (expressed in terms of mental effort, physical effort, time spent and risk to the patient) was affected by comorbidities or chronic problems listed.

Carrier Considerations

• CGS is therefore instructing the auditor to evaluate the record not only the documentation elements but also on the affects the physician work had based on the complexity of care of the patient- but keep in mind this is as it is demonstrated through clinical analysis and impressions of the documentation- as the auditor should never abstract the records for clinical content unless they are of equal clinical expertise as a NPP or Physician.
Carrier Considerations

• Novitas Medicare has one of the more compelling statements as to the scoring of medical necessity:

• Medical necessity cannot be quantified using a points system. Determining the medically necessary level of service (LOS) involves many factors and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to:
  • Clinical judgment
  • Standards of practice
  • Why the patient needs to be seen (chief complaint),
  • Any acute exacerbations/onsets of medical conditions or injuries,
  • The stability/acuity of the patient,
  • Multiple medical co-morbidities,
  • And the management of the patient for that specific DOS.

Carrier Considerations

• While some of these points are clinical concepts, many would argue that non-clinical individuals should not be attempting to access these within the documentation. But the argument truly is, if the documentation clearly painted a portrait of the patient as CMS clearly indicates it should, then this information would not have to be abstracted by the auditor.
When considering the medical necessity of the encounter, what should be considered?

• We are trying to rate the overall complexity of care that occurred during the encounter in taking care of the patient.
• CMS indicates that the presenting problem should drive the medical necessity of the encounter.
  • This is not just the presenting problem as it relates to the chief complaint, but how the presenting problem affects the complexity through the needed examination, testing, and eventual plan of care.
  • So the accessing the presenting problem through the entire episode of care.

STEPS TO DEFINING MEDICAL NECESSITY

The history begins by telling the presenting problem (chief complaint) of the patient encounter and then defining how severe the effects on the patient are at this time through the HPI, ROS, and PFSH. This should accurately define the severity of the patient according to the patient’s own interpretation analysis of their condition. The auditor should equate the condition to the level of risk according to the patient’s presenting problem.
STEPS TO DEFINING MEDICAL NECESSITY

We know that after reviewing the patient’s history, the provider will perform the exam and review the findings of labs/x-rays/testing and should then be able to define the complexity of the overall care of the patient within the plan of care according to the documentation.

STEP 2
Consider the assessment of the provider’s analysis of the patient.

STEP 3
Consider the combined overall complexity of the patient.

There are some rules of thumb that encourage driving the medical necessity from the chief compliant only and others that indicate it the MDM should drive the medical necessity only, but as we noted above CMSs interpretation and the outlining by Novitas- it should not merely be one or the other of these, but rather the overall complexity assessment of the entire encounter.

Therefore, we should consider how the patients stated severity differ from the providers documented analysis and assessment of the patient’s severity and use these to balance the medical necessity.
Putting the steps together

Why is balance needed? Because some patients will have a reported severity of being high as maybe they are hypersensitive to pain or their symptoms but the provider’s overall findings may indicate the patient’s problem is not as severe as they indicated with their history in the subjective portion of the documentation. Furthermore, the history information may have been over-documented which at first thought could support higher complexity, but when analyzed against the providers POC in the MDM the balance of the appropriate level is found.

Analyzing Medical Necessity

- By analyzing the presenting problems effects on the entire episode of care and then comparing that to the complexity of care represented by each level of service, we can make decision of the level of medical necessity the documentation of the encounter portrays. The following charts equates the risk to the presenting problem and correlates it to the appropriate level of service for the medical necessity of the encounter.
Medical necessity reviews MUST be a part of every audit in order for the review to be effective.

There must also be balance between the documentation content and the medical necessity.

Default to the lower level of service.

Documentation guidelines must also be met for that level of service in order for the code to be fully supported.

If you are not a clinician, do NOT try to abstract clinical necessity. Base ALL interpretations how the provider painted the portrait of the patient in the documentation.

Medical necessity is the overall analysis of the complexity of the full episode of care. Medical decision making is the "bean counting process" of medical auditing.

An auditor should NOT assume or interpret! The provider is responsible for connecting the dots of the complexity of care provided to the patient.

While the chief complaint sets the overall "tone" of the medical encounter it is NOT the only point to consider within the medical necessity.

Guidelines allow 2 of the 3 key components for established patients, and national guidance does NOT state that MDM must be one.

Be cautious in this teaching method!
Evaluating the Complexity of the HPI

“Patients presents with knee pain that has been ongoing for quite sometime. She has tried physical therapy with little relief. Reports swelling in the joint.”

REVISED:

“Patient presents with Right knee pain that has been a complaint for the past year. The pain is chronic and severe in nature often times limiting ADL’s. She reports swelling in the joint which increases her pain to a severity of 8/10.”
Evaluating the Complexity of the ROS

“As per the HPI, all other systems are negative as they relate to the chief complaint.”

REVISED ROS:

“The patient has no numbness, tingling, radiating pain, or bowel bladder dysfunction. Additionally, all other systems are negative.”
Evaluating the Medical Complexity of the Plan of Care

“Continue Rx as prescribed and RTC in two months.”

REVISED PLAN OF CARE:
“Continue Naproxen 250 mg QD and re-evaluate the patients condition in two months with repeat x-rays. At that time if no improvement will consider MRI.”

3 Medical Necessity Myth Busters

# of Diagnoses
The number of diagnoses coded and documented does NOT always affect the level of service.

Prescription Meds
Writing a prescription does not guarantee the level of service will support a 99214 encounter.

EMR Wizard
EMRs give SUGGESTED coding levels because they cannot access medical necessity.
NAMAS
National Alliance of Medical Auditing Specialists

Shannon O. DeConda
10401 Kingston Pike
Knoxville, TN 37922
877.418.5564
namas@namas.co
www.namas.co

Questions?

• Thank you for your attendance!

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  http://www.pmimd.com/pmiForums/rules.asp