Welcome to Practice Management Institute’s Webinar and Audio Conference Training. We hope that the information contained herein will give you valuable tips that you can use to improve your skills and performance on the job. Each year, more than 40,000 physicians and office staff are trained by Practice Management Institute. For 30 years, physicians have relied on PMI to provide up-to-date coding, reimbursement, compliance and office management training. Instructor-led classes are presented in 400 of the nation’s leading hospitals, healthcare systems, colleges and medical societies.

PMI provides a number of other training resources for your practice, including national conferences for medical office professionals, self-paced certification preparatory courses, online training, educational audio downloads, and practice reference materials. For more information, visit PMI’s web site at www.pmiMD.com

Please be advised that all information in this program is provided for informational purposes only. While PMI makes all reasonable efforts to verify the credentials of instructors and the information provided, it is not intended to serve as legal advice. The opinions expressed are those of the individual presenter and do not necessarily reflect the viewpoint of Practice Management Institute. The information provided is general in nature. Depending on the particular facts at issue, it may or may not apply to your situation. Participants requiring specific guidance should contact their legal counsel.

CPT® is a registered trademark of the American Medical Association.
The Role of Medical Necessity in Determining the Level of an E&M Visit

Jeffrey Restuccio, CPC, COC, MBA
Memphis TN
(901) 517-1705
jeff@Ritecode.com
www.Ritecode.com

Agenda

1. Overview
2. Medical Decision Making (MDM)
3. MDM Scoring System
4. Why is Medical Necessity (MN) More important than MDM?
5. CPT version
6. The AMA Perspective
7. Medicare Guidelines
8. The Problem with Problem Lists
9. The concept of Peer Review
10. The concept of the 50/50 Rule (of auditing)
11. Gray Areas
12. Your Questions
Traditional Office Visit Coding

- Determine if an E & M code is supported by documentation. Determine if the patient is new or established.
- For E & M codes, determine the level of the code based on the **history**, **exam** and **Medical Decision Making (MDM)**.
- Historically—and for the majority of medical coders, MDM has been the primary determinant of the level—not the history or exam. The **MDM scoring system** is the most consistent and quantitative.
- Alternatively, **Time** is used when Counseling or Coordination of Care dominates (over 50%) the encounter and properly documented.

Medical Necessity (MN)

Per Medicare:
- A provider should not perform or order work (or bill a higher level of service) if it’s not “necessary,” based on the nature of the **presenting problem**.
- Per the **Medicare Claims Processing Manual**, chapter 12, Physicians/Nonphysician Practitioners, section 30.6.A:
  
  “Medical necessity of a service is **the overarching criterion for payment** in addition to the individual requirements of a code.”

- Concerning the level of an E & M code, this is new information, not in the CPT manual. Also this definition is not the same as the **billing definition for tests and procedures**.
Medical Necessity Defined

• According to the Centers for Medicare & Medicaid Services (CMS) Medicare Program Integrity Manual (IOM), Chapter 13, Section 5.1., when assigning an E/M level, medical necessity means:
  “the service is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition.”
  – Note that this refers to E & M codes, not diagnostics or surgeries.
  – The problem is that this could mean anything. Nowhere does Medicare quantify how to determine whether the visit is a level 4 or a level 5 based on Medical Necessity.

Medical Necessity

• Technically the Medical Necessity argument could be used to justify:
  – Downcoding encounters
  – Upcoding encounters
• It also applies to the frequency of office visits for a given condition.
• It could impact any level of code but would be most significant with level IV (4) and V (5) codes.
• 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 (based on medical necessity).
• According to Medicare, “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.”
The American Medical Association (AMA) policy H-320.953[3] defines medical necessity as:

• Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:
  a) in accordance with generally accepted standards of medical practice
  b) clinically appropriate in terms of type, frequency, extent, site and duration
  c) not primarily for the convenience of the patient, physician, or other health care provider.

The Medicare Benefit Policy Manual, chapter 16, section 20, similarly defines medical necessity as:

“services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and not excluded under another provision of the Medicare Program.”*
Title XVIII of the Social Security Act, Section 1862 (a) (1) (a):

Reads similarly:

“No payment may be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

NHIC Definition

- NHIC in its 2009 Medicare Part-B Provider Education article, *Evaluation and Management (E/M) Coding Requirements*. Under the subheading *Establishing Medical Necessity*, it states:

  The chief complaint or reason for the encounter establishes the medical necessity and reasonableness for services. It is a concise statement describing the symptom, problem, or condition, diagnosis, physician recommended need(s), or other factor that is the reason for the encounter, usually stated in the patient’s words. It is sometimes referred to as “presenting” problem.”
NHIC Definition

- After establishing this relationship between the presenting problem and medical necessity, the article continues: “The medical necessity and reasonableness of the level of service billed is directly correlated to the nature of the presenting problem.”

If you have ten providers and one or two consistently upcode, adding Medical Necessity to your compliance arsenal could be a useful investment if your attempts to get them to stop are not successful. The key is to continually improve documentation and the justification for the level.

Implications of Medical Necessity

- URI versus chronic cough or a common cold
- SOB and chest pain
- Heart problems and specificity
- ARMD, wet form versus the dry form
- Intrinsic asthma versus extrinsic asthma
- Viral versus bacterial infections
- Older patients and co-morbidities
Potential for severity

• Lump in breast: an undiagnosed new problem with uncertain prognosis (moderate severity)
• Chest pain: could be a heart attack or other heart problem
• Blurred vision: Could be a sign of a stroke or other neurological problem or serious ophthalmological problem
• SOB: Shortness of breath could be an indication of numerous pulmonary or heart problems

The “Presenting Problem”

• This answers the question: “Why is the patient here today?”
• One could call it a subset of the concept “chief complaint.” The difference is that without a presenting problem the visit is preventive and should be coded as such.
• The presenting problem (PP) should be documented in the chief complaint. One could have a CC without a PP (annual well exam).
Chief Complaint

The CC must be a medical reason for returning. While it should be “in the patient’s own words”, the documentation should reflect a disease, condition, signs, symptoms or paid screening. These are not good CC or PP:
- F/U
- Review for labs
- Here for test (stress test, EEG)
- My wife told me to come.

- Remember that the clinic is at risk if you’re audited and the CC is not valid.

CC and Assessment

- During audits, it is often noted the Assessment (MDM) does not correlate to the chief complaint. One such example would be the HPI supports a follow-up visit for renal functions tests, hypertension, and reflux.
- The medical management of that patient is then a physical therapy referral for low back pain, with no mention of medical management of the issues that brought the patient to the clinic.
- The documentation did not support complaints of low back pain. Part B Medicare has also noted that the plan of care simply lists the medical diagnoses of the patient, with no mention of changes to the plan of care if any, or continuation of current treatment regimens.
- It is difficult to determine the medical necessity of a visit when the documentation lacks important information, or when the documentation does not support medical management of the patient’s chief complaint.
Involve the Front Office

• Everyone, including the receptionist and scheduling staff should receive training on proper chief complaint, history, past, social, and family history, HPI, and ROS questions.
• Understanding what a routine exam or screening means.
• They should ask basic questions (e.g., SOB, fatigue, joint pain, headaches). Some conditions such as HTN, Diabetes and Glaucoma can be asymptomatic unless severe.
• What medications and other medical conditions can impact your specialty?
• New employees must be trained.
• Quarterly spot-audits should be conducted of documentation. Compliance is a constant process.

Medical Necessity

Medical necessity cannot be quantified using a points system. However, conditions can be ranked. Determining the medically necessary 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:

1. Clinical judgment
2. Standards of practice
3. Why the patient needs to be seen (chief complaint)
4. Any acute exacerbations/onsets of medical conditions or injuries.
5. The stability/acute of the patient
6. Multiple medical co-morbidities
7. The management of the patient for that specific DOS.
Medicare NCD/LCD

- Services must meet specific medical necessity requirements in the statute, regulations, and manuals and specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations (if any exist for the service reported on the claim).
- For every service billed, you must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.
- Generally all the NCD/LCD does is list all diagnoses that support reimbursement (aka medical necessity) for a service or procedure.
- In previous presentation I’ve personally stated that medical necessity was a billing issue only. That is no longer true.

RVU’s 2017 (Atlanta GA)

<table>
<thead>
<tr>
<th>E &amp; M</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>2.11</td>
</tr>
<tr>
<td>99203</td>
<td>3.05</td>
</tr>
<tr>
<td>99204</td>
<td>4.63</td>
</tr>
<tr>
<td>99205</td>
<td>5.83</td>
</tr>
<tr>
<td>99212</td>
<td>1.23</td>
</tr>
<tr>
<td>99213</td>
<td>2.06</td>
</tr>
<tr>
<td>99214</td>
<td>3.03</td>
</tr>
<tr>
<td>99215</td>
<td>4.08</td>
</tr>
</tbody>
</table>
### Medicare Allowable 2017 (Atlanta GA)

<table>
<thead>
<tr>
<th>E &amp; M</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>$ 75.81</td>
</tr>
<tr>
<td>99203</td>
<td>109.60</td>
</tr>
<tr>
<td>99204</td>
<td>166.36</td>
</tr>
<tr>
<td>99205</td>
<td>209.48</td>
</tr>
<tr>
<td>99212</td>
<td>44.19</td>
</tr>
<tr>
<td>99213</td>
<td>74.01</td>
</tr>
<tr>
<td>99214</td>
<td>108.85</td>
</tr>
<tr>
<td>99215</td>
<td>146.58</td>
</tr>
</tbody>
</table>

### Why Not Just Use Time-Based Services?

- **Using counseling and time** is an alternative reporting option for encounters that do not support higher MDM or Medical Necessity.

  *It is not acceptable to simply state "35 minutes spent with patient discussing treatment."*

- When counseling and/or coordination of care is the key factor is determining LOS, documentation needs to support the amount of time spent in discussion and detail the context of the conversation and any decisions made or actions that will result based on this counseling. Always report two times and counseling must be 50% or more of the total time.
Top Deadliest US diseases/conditions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Heart disease</td>
</tr>
<tr>
<td>2</td>
<td>Cancer</td>
</tr>
<tr>
<td>3</td>
<td>Chronic lung diseases</td>
</tr>
<tr>
<td>4</td>
<td>Stroke</td>
</tr>
<tr>
<td>5</td>
<td>Alzheimer’s Disease</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>7</td>
<td>Influenza and pneumonia</td>
</tr>
<tr>
<td>8</td>
<td>Chronic kidney disease</td>
</tr>
<tr>
<td>9</td>
<td>Septicemia</td>
</tr>
<tr>
<td>10</td>
<td>Chronic liver disease and cirrhosis</td>
</tr>
</tbody>
</table>

Signs and Symptoms

- Extreme thirst, dry mouth, increased urination and blurred vision are often the first signs of diabetes.
- Bloating, fatigue, gastrointestinal upset, back pain, arm pain, nausea and sweating could be signs of a heart attack.
- Slurred speech, paralysis, weakness, tingling, burning pains, numbness, and confusion are signs of a stroke.
- Black, tarry stools may indicate a hemorrhage from an ulcer of the stomach or the intestine.
- A severe headache could be many things: bacterial meningitis, bleeding in the brain, and even a brain aneurysm. But most are simply tension headaches.
- Past history as well as family history should be noted in the assessment when documenting rule-outs. Without a confirmed diagnosis the signs and symptoms above would only qualify for low MDM or a 99213. Using medical necessity you could report a higher code.
Comparing Medical Specialties

• With certain specialties, particularly, oncology, cardiology, neurology, and pulmonology it could be argued that the condition for which the patient is being treated will ultimately kill him/her. However, medical necessity should be read as license to score every cancer patient or every postsurgical heart patient as a level V.

• Do you know the national utilization distribution of office visit codes for your specialty? If nationally level V encounters are only one percent of the total, is your specialty five or even ten percent?

Medical Necessity and Common Sense

• Used judiciously, medical necessity can be used to report a higher code for encounters that do not meet the MDM requirements for a level V as well as support more level V encounters per your specialty.

• However, your documentation must be impeccable!

• Before you use MN ensure that your Hx, Exam and MDM documentation is flawless. Be sure to improve your ICD-10 specificity. Audit your EMR software for inaccuracies and cloning.
Not only highest level encounters

• Medical necessity can be used to support your level III codes if an ambitious auditor recommends downcoding your one, stable chronic condition encounters to a level II based on MDM.

• Technically, a new diagnosis, not self-limited, is three points on MDM Table A. If the patient has three chronic illnesses: DM, HTN, and COPD, then with proper exam and hx the encounter is a safe level IV. (But do note that if there documentation is lacking in many sections, or cloned, and there are thousands of similar Level IV’s, you do not want to chance an auditor could downcode them based on medical necessity. That could happen.)

• If the new diagnosis is self-limited then it is only one point, not three per the scoring system.

Minor Ailments And Self-limiting Conditions

• Technically a self-limiting disease is:
  “a disease process that resolves spontaneously with or without specific treatment or which has no long-term harmful effect on a person’s health.”

• Common examples:
  – Common cold
  – Insect bites (except poisonous or stings)
  – Tinea corporis
  – Sinusitis
  – Ear infection
  – Benign lesion
  – Dermatitis
Complications from Strep Throat

- **Audit:** A pediatric clinic wanted to report all new strep throat encounters as a level IV (99214). I considered strep throat “self-limited” and audited them all of them as a level III (low MDM). How could medical necessity be used in this situation?
- Strep throat usually goes away in 3 to 7 days with or without antibiotic treatment. However, if untreated, strep throat can cause complications, such as an abscess of the tonsils, kidney inflammation, or rheumatic fever.
- Document if the patient’s immune system compromised or anything in the family history to cause additional concern?
- Be sure to document that a lab was performed to confirm group A streptococcus.

Ultimately your OV level needs to pass any audit—not the opinion of an individual external auditor. Since pediatrics would not involve Medicare, you would have to pass a Medicaid or private insurance review. Assume your clinic will allow 5%, 25% or even 100% of strep throat encounters to be reported as a level IV (99214) based on moderate MDM and the Medical Necessity of the encounter.

- Based on my 50/50 auditing rule, I would recommend against 100%, however, when the medical necessity warrants, a higher level code could be used. Many providers may want to use a higher level code because they spent more time with the patient. Even though this may be true and valid, no auditor would accept that argument (unless it was a counseling visit). The percentage reported at a higher level should have similar additional documentation.
Medical Necessity Strategy

• Document if the strep throat is recurrent.
• Document your discussion or preparation for a tonsillectomy.
• Document and report other conditions such as dysphagia, headache, nausea and vomiting and swollen lymph nodes.
• Note that technically three signs and symptoms (or self-limiting diagnoses) cannot support moderate MDM in Table A per the MDM scoring system; however, based on medical necessity it could be argued that a level IV is warranted.
• Document rule-outs for kidney inflammation or rheumatic fever if appropriate. Document any co-morbidities.

Please understand that medical necessity is as much art as science. These are suggestions only and not a guarantee that these arguments will be accepted by your auditing party.

Dermatology

What is considered self-limited or minor?
• New mole diagnosed as a Melanocytic Nevi (benign).
• Acne
• Dermatitis
• Eczema
• The key is being consistent. If the condition is reported as a level IV (99214/ moderate MDM) then there must be justification.
• As an auditor, if the problem is simply watched, considered cosmetic, with little chance for complications I would consider it self-limited.
• Don’t confuse a new problem with the self-limited discussion.
• Established or chronic problems are one MDM point each. Are they being treated or just watched? If a patient had three skin conditions that were all being watch and not treated, then I would put that at 50/50 and recommend they be reported as self-limited.
Digestive Problems

- **Signs and Symptoms**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sign or Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>Depression or anxiety</td>
</tr>
<tr>
<td>Abdominal pain and bloating</td>
<td>Tingling numbness in hands and feet</td>
</tr>
<tr>
<td>Painful swallowing</td>
<td></td>
</tr>
<tr>
<td>Food intolerance</td>
<td>Rectal bleeding</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Itchy skin rash (dermatitis</td>
<td>Vomiting</td>
</tr>
<tr>
<td>herpetiformis)</td>
<td>Constipation</td>
</tr>
</tbody>
</table>

- **Potential Diagnoses**: GERD, IBS, IBD, Gastroparesis, and Celiac disease.

Neurological Problems

- **Long-term MS, Parkinson's, Alzheimer's, brain damage, spinal cord injuries, stroke, and muscular dystrophy patients**: if the condition is severe are all these encounters high medical necessity (MDM) and reported as level V codes? There are more than 600 neurological disorders!

- **Create a list of conditions from your practice management system based on ICD-10 codes**. With coding and clinical staff determine which ones are most severe and rank them. Determine when they warrant a level V code. Remember that time cannot be used to justify the level! Use both MDM and Medical Necessity but be prepared to justify both. Include mental impairment information to justify the MN level.
Potentially Serious Eye Symptoms

1. Blurred vision
2. Red eye
3. Eye pain
4. Flashing lights, floaters, or a gray shadow in the field of vision.
5. Persistent discomfort in the eye
6. Eye injury
7. Complication from eye surgery
8. Any loss of vision, particularly if sudden or in one eye.

Does this mean that I could use medical necessity to report a level 5 encounter based on the above diagnoses?

Think Jury of your Peers

This applies to all specialties
Are all ROS and all Exam elements medically necessary for:
• URI
• Headache
• Back pain
• Diabetes
• SOB
• Chest pain
• The main argument from many providers is that sometimes a minor complaint could be a sign of a much more complicated problem. However, this line of reasoning should not be overused as minor signs and symptoms could be indicative of many things.
Hypertensive Retinopathy Example

- Diabetes Type 1: stable chronic illness (low severity)
- Glaucoma, cataracts and hypertensive retinopathy (Total of four presenting problems.)
- Hypertension; smoker
- HTN and smoking are exacerbating Bobby Joe's hypertensive retinopathy (HR). The damage can be serious if hypertension is not treated. The provider performs a comprehensive Hx and Exam. About 50 minutes is spent explaining the situation to the patient.
- The severity rises from moderate to high based on Medical Necessity. Be clear this is a worsening of the HR. Remember the time is irrelevant (to the auditor).

This information makes it possible for an auditor to approximate the severity of the presenting problem and the level of medical necessity for each case — and then identify the appropriate E/M level.

**Think:** Jury of your Peers; Clinical Guidelines; Reasonable and Necessary.

Have a disease ranking list or medical journal article indicating the medical necessity of the condition; in this case Hypertensive Retinopathy.

Make sure your office manager and Clinical Director understand that they need to pass a review from a medical records auditor who may or may not be versed in the particulars of your specialty.
Rule-Outs and Medical Necessity

• CPT and Medicare rules indicate that any diagnoses listed as: rule-outs, likely, possible, or with a question mark either before or after, are not confirmed diagnoses and cannot be reported to support medical necessity (linked to a CPT code). Note that this refers to diagnostic and surgical procedures or what I refer to as the billing definition of Medical Necessity.

• However, concerning Medical Necessity to determine the level of the encounter, documenting the systematic rule-out of the most severe and threatening illnesses is recommended. In the event of an audit, show the clinic’s use of this to support medical necessity that warrants the higher level.

• The providers do not have to “write a book” but be clear and succinct.

Document Co-Morbidities*

• The following conditions are particularly important for pre-surgery screenings

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous heart attack</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Obesity</td>
</tr>
<tr>
<td>Glaucoma for cataract surgery</td>
<td>Immune system disorders</td>
</tr>
<tr>
<td>Previous stroke</td>
<td>Collagen vascular disease (disorders)</td>
</tr>
<tr>
<td>Neurological conditions</td>
<td>Advanced Age</td>
</tr>
</tbody>
</table>

*Already recommended to support MDM: Table of Risk Column C. These support both MDM and Medical Necessity.
Clinic Code Selection Strategy

- Most auditors won’t challenge you if you clearly understand and follow:
- E & M code selection and Hx, Exam, and MDM fundamentals.
- The MDM scoring system and make that a documented part of your compliance plan (training, auditing, and review).
- Include a clear and concise approach to use of medical decision making to determine your selection of code levels.
- After over 10,000 audits the vast majority of errors are for the most basic, coding 101 errors. Most providers appear to be unaware of MDM level selection and basic scoring of encounters. Copy and Paste is evident (everywhere). Most assume their EMR software does this for them. It does not.

Compliance Plan

- Every clinic should have a formal, written, compliance plan—even if it is only one page for a small office.
- Ritecode offers a 38-page compliance plan for multiple specialties. This would be appropriate for medium to large offices.
- Add your methodology and examples for using Medical Necessity to determine the level of encounters—especially when MDM does not support a High level.
Create an internal ranking diseases

• Create a short overview of your top 5 conditions that support a higher medical necessity value than the MDM would support.
• Focus on the documentation to support the use of medical necessity in the absence of clear scoring criteria.
• Just having this documented (written down) in your compliance plan should put you light-years ahead of other clinics in your specialty.

Eyecare Ranking Example (6 is most severe)

<table>
<thead>
<tr>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>subconjunctival hemorrhages (1)</td>
<td>penetrating eye injuries collapsing the eyeball with intraocular foreign body (6)</td>
</tr>
<tr>
<td>Pterygia (1)</td>
<td>panophthalmitis with infection following surgery (6)</td>
</tr>
<tr>
<td>noninfectious conjunctivitis (1)</td>
<td>perforating ulcer of the cornea (5)</td>
</tr>
<tr>
<td>ophthalmic migraine (2)</td>
<td>Retinal artery occlusion (6)</td>
</tr>
<tr>
<td>vitreous floaters (2)</td>
<td>retinal detachment (5)</td>
</tr>
<tr>
<td>Contact lens, mechanical complication (2)</td>
<td>acute binocular diplopia with neurological symptoms (5)</td>
</tr>
</tbody>
</table>

Consensus on Severity for Ocular Emergency: The BAASIC SEverity Score for Common Ocular Emergencies [BaSe SCCoE]  
https://www.hindawi.com/journals/joph/2015/576983/
Medical Decision-making (MDM)

- Per the CPT® codebook, Medical Decision-making (MDM) “refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by “three criteria categories.”
- MDM can be quantified according to this criteria, and associated with an evaluation and management (E/M) level for each E/M category. The scoring system is consistent and teachable.
- Outside of the CPT manual, there is a commonly-used MDM scoring system. This was originally developed by the Marshfield Clinic (in Wisconsin), not the AMA or Medicare. However, several Medicare Jurisdictions and many auditors have adopted it.

MDM debate

- Historically, when auditing I have used MDM as the single best indicator of the overall E/M level.
- The level can be scored by determining the nature of the presenting problem, number of treatment options, etc...
- MDM is a reliable indicator of overall E/M level because it cannot be compliantly over-documented as a history or exam.
- Determination of medical necessity, however is a clinical decision, and is not so easily quantified.

There are more gray areas.
MDM and Medical Necessity

• Based on Medical Necessity, automatically assuming that MDM will always point to the correct E/M level could lead to under-coding.
• Because of the gray areas and the inherent complexity, upcoding encounters based on medical necessity should be done only after the clinic has conducted a thorough plan to optimize compliance at every level.
• In the event of an audit, coding staff and providers need to be able to articulate the severity of diseases in a peer review environment and be able to back up any assertions.

Compare and Contrast

• MDM and medical necessity are very different concepts although related. And although both are important, medical necessity — which unfortunately is the more difficult concept to quantify — is the more important factor when selecting an E/M service level.

<table>
<thead>
<tr>
<th>MDM</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part of CPT and 1997 guidelines</td>
<td>Not part of CPT or 1997 guidelines</td>
</tr>
<tr>
<td>Quantitative</td>
<td>Mostly related to billing</td>
</tr>
<tr>
<td>Considered by many the main determinant of an E &amp; M Level</td>
<td>Medical necessity of a service is the overarching criterion for payment</td>
</tr>
</tbody>
</table>
## Compare and Contrast

<table>
<thead>
<tr>
<th>MDM</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three Tables, 2 of 3</td>
<td>Urgency, Potential Complications</td>
</tr>
<tr>
<td>Table 3 (Table of Risk)</td>
<td>Co-Morbidities / Other conditions</td>
</tr>
<tr>
<td>Self-limited or not?</td>
<td>Signs and Symptoms, Potential</td>
</tr>
<tr>
<td>Organ threatening but stable</td>
<td>COPD, stroke, post heart surgery, ARMD</td>
</tr>
<tr>
<td>4 or more stable chronic Dx</td>
<td>How/Why does it warrant a level V?</td>
</tr>
<tr>
<td>Acute severe exacerbations</td>
<td>Not a problem; same for both</td>
</tr>
</tbody>
</table>

## E & M 2 of 3 Rule

- This applies to an established patient where only two of the three key exam elements are required for a given level (hx, exam, and MDM).
- Neither CMS nor CPT® guidelines specifically require MDM to be considered when two of three key components (hx, exam, MDM) must be met for an established patient.
- Medical Necessity is not referenced in the 1997 E & M guidelines from Medicare.
- However, many coders interpret the discussion on medical necessity in section 1862(a)(1)(A) of the Social Security Act (SSA) to mean that MDM must be one of the two key components.
Must MDM be one of the 2 for an established patient?

- Instruction from the American Medical Association (AMA) in CPT® Assistant implies that:
- “the history or exam elements should be recorded only to the extent that MDM requires them.”
- Individual payers might have specific rules regarding MDM as a “must” for one of the two components (2 of 3) for established patients; however, this is not a requirement of the American Medical Association or the Centers for Medicare & Medicaid Services’ national policy.
- However this is misleading.

2 of 3 Rule

- If MDM must be one of the two key components [per SSA above] and the history or exam elements should be recorded only to the extent that MDM requires them [per AMA CPT Assistant] then it follows that MDM is the main determinant of the level of service for an office visit.
- The takeaway is that there is debate on the 2 of 3 rule and the importance of MDM. And adding a fourth component: “Medical necessity is the overarching determinant...” just makes compliance and auditing more difficult and subject to interpretation.
- Knowledge is power and the challenge is to establish a level of compliance so the providers are compensated appropriately.
Could your MDM scoring be challenged?

- The benefit and risk of Medical Necessity is that it could be used either to report a higher or a lower level than traditional hx, exam and MDM warrants.

- Example: three stable chronic diseases and 99214/99204.
- Example: one stable chronic disease and 99213/99202.
- Example: older patient, three conditions managed and relevant today and spent about 60 minutes with the patient. Do you report the encounter based on time, a 99214 or use medical necessity to report a higher code? How would you support it?

Is UnderCoding considered Fraud

- Undercoding services is both a compliance failure and a missed opportunity to capture legitimate reimbursement.
- Technically it is a legal issue and a financial issue—not a coding compliance issue.
- In my 20 year career I have heard of one instance where a clinic was actually reimbursed for undercoding (Medicare paid them more for the encounter); however I consider that rare and hesitate to encourage clinics to upcode a clearly downcoded encounter unless the documentation is impeccable. Most often there are numerous small errors or inconsistencies in documentation.
Cloning, MDM and Medical Necessity

- Notes with excess or irrelevant information for the presenting problem(s) (especially if those notes are generated electronically) should be reviewed for cloning. While audits indicate it is roughly 25% of clinics, I see evidence of cloning (copying and pasting notes or copying from a previous encounter) in virtually all EMR notes.
- An active program to always include notes unique to this date of service and patient (avoid cloning) will help ensure compliance and help support the use of Medical Necessity if MDM does not support the level.

Notes Unique to this patient and DOS

- I increased Mary Sue’s dosage of Xalatan, Timilol, etc… to xxx.
- I discussed with Bob the options between adding a new class of glaucoma medication or trabecuoplasty.
- I explained to Joe Adams the difference between dry ARMD and wet ARMD and prognosis.
- Discussed the impact of smoking, diabetes, or hypertension on the eyes with Adriane today.
- Bottom Line: if the note is generic and meaningless (provides no new unique information to this patient or DOS) I audit is as cloned. Cloning is subjective but the number one problem with EMR notes.
It’s not just level, it’s also *Frequency* (1 of 2)

- These notes are from Trailblazer, formerly the Medicare carrier for TX. In addition, the actual example was not glaucoma but the thought process would be same:

**Trailblazer Audit Comments**

- “The patient presented with a single, chronic, well-controlled problem. Unfortunately, the practitioner’s explanation of the nature of this patient’s problem is too vague to get even a sense of whether this service is at all medically necessary. [Glaucoma] is a chronic problem that appears to be stable in this patient. *Is a three-month follow-up reasonable and necessary for stable [glaucoma]?*

- Why or why not? Those are the questions the information in the record should address for Medicare payment to be determined appropriate.

---

It’s not just level, it’s also *Frequency* (2 of 2)

**Trailblazer Audit Comments:**

- “If one assumes this was a medically reasonable and necessary visit, what level of service is needed for a follow-up visit with a patient who has one stable problem (for which the likelihood of death or disability before the next visit is very unlikely)?

- The answer is that this visit would appropriately be paid as a low-level E&M service, **probably code 99212**. Consequently, while the very brief HPI and medical decision-making could be appropriate for the care of this patient’s [glaucoma], the comprehensive ROS and examination exceeded the level of care needed for the patient’s presenting condition.”

[common with EMR systems and cloning - Jeff]
Note from CGS (a Celerian Group Company)

During repeated reviews, we have observed the tendency to "over document" and consequently to select and bill for a higher level E/M code than medically reasonable and necessary. **Word processing software, the electronic medical record, and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information.**

- Even if a "complete" note is generated, only the **medically reasonable and necessary services** for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service.
- **Information that has no pertinence to the patient's situation at that specific time cannot be counted.**

The takeaway is that even with properly reported Hx, Exam, and MDM Medicare could disallow a claim–based on medical necessity – Jeff.

https://www.cgsmedicare.com/partb/mr/articles/em_volume.html

Noridian Medical Necessity Versus MDM Argument

- The Noridian Part B Medical Review (MR) Department has noticed, during prepayment medical review, the provider community is using a **quantification method [MDM scoring]** to code their claims. [notes are mine – Jeff]
- **Per Noridian:** “The **amount of data** contained in the medical record should not be the controlling factor for determining the level of service (LOS).”
- It is neither acceptable nor appropriate to include **additional information** in the medical record for the sole purpose of meeting the billing requirements for a specific Current Procedural Terminology (CPT) ® code.
Noridian Medical Necessity Versus MDM Argument

- Providers may include any and all data that they deem **appropriate** in their patient's notes.
- Per Medicare regulations, providers are required to bill only for the elements that are **medically reasonable** and **necessary** for the treatment of the patient.

What this means is Noridian is warning against padding or adding irrelevant or extraneous information just to get paid. The Hx and Exam should succinctly refer to the PP and assessment. - Jeff


Noridian Questions

- They are well aware of the MDM point system widely used.
- How do they define “**amount** of information?” Is it a word count? I think this refers to the fact that with EMR systems most every patient has a comprehensive Hx and Exam.
- How do they define “**additional information**?” Who determines what is additional and what is necessary or relevant? Same comment as above.
- How do you determine “**what is appropriate**?”

Per Medicare regulations, providers are required to bill only for the elements that are:

“**medically reasonable and necessary for the treatment of the patient.**”
My Answers

• My answers below are my personal consulting opinion based on over 20 years of experience and 10,000 audits.
• “amount” of information?” This relates to the history, exam, and Assessment (MDM) portion.
• “additional information?” If a jury of your peers consider the services or elements not medically necessary,
  – Never simply list or pull down a list of diagnosis codes as your Impression/Assessment.
  – List and document the status of only those conditions that are relevant and managed today.
  – Never use a Problem List as your Assessment/Impression.

The Problem with Problem Lists

• Noridian Part B MR has also noticed that providers are crediting themselves for a list of diagnosis codes and/or medications included in the HPI when determining the Level of Service.
• While it is appropriate to document the patients past medical history (PMH) and list of current medications, it is not appropriate to have those elements taken into consideration determining the level of a key E&M category.
• A problem list is in the history section.
• The impression/assessment is a separate and discrete section.
• They cannot be used interchangeably.
My Answers

• How do you determine “what is appropriate?”
  Per Medicare regulations, providers are required to bill only for the elements that are:
  “medically reasonable and necessary for the treatment of the patient.”
• This now relates to Clinical Guidelines and Peer Review.
• Refer back to Strep throat and uveitis examples. Would 50% of these encounters be considered severe enough to warrant a higher level code? Probably not but perhaps 5% would.
• Use your data to create your top five scenarios. It does not need to be a book, one page each.

NHIC Medicare

• NHIC mirrors the CMS position on Medical Necessity over the individual requirements of a CPT® code,
  “In addition to the medical necessity and reasonableness of an E/M service, the components of History, Examination and Medical Decision Making are the 3 key components in selecting the appropriate level of service.”
Plan for Action

• Medical necessity is directly linked to improved and specific ICD-10 coding.
• Avoid unspecific codes: ARMD, asthma, pain and headache.
• Train front-office staff to ask the correct questions.
• Always obtain a valid CC/Presenting Problem.
• Ensure your patients know why they are seeing the doctor (name of their condition).
• Ask about asymptomatic conditions such as glaucoma and HTN.
• Be sure the clinic has an up-to-date LCD for every procedure performed. Generally you won’t find one for office visits (rare).

Plan for Action

• Perform a utilization review of all your providers and office visit codes.
• Calculate the actual versus estimated number of level V encounters per year (per provider). Also review level 3 and 4 codes.
• Get Provider buy-in for training and implementation. Conduct peer audits.
• Ensure top level management is on board.
• Ensure a compliance plan is documented, up-to-date and implemented (frequent audits and training).
• Ensure all coders and providers understand the basics of determining the level of an office visit and MDM scoring.
• Establish your top five Medical Necessity scenarios where a higher level visit is warranted even if the MDM does not support it.
Plan for Action

- Note that if your providers are retinal specialists or work the E/R (injuries) that their percent of high-level visits will be higher than the roughly one-percent. Don’t lose revenue by purposely under-coding—audit proof your documentation!
- Increase the documentation of “rule-outs” if the provider suspects a serious problem from a sign or symptom.
- Avoid and reduce cloning.
- Avoid Problem lists.
- Vary the Hx and Exam to match the medical necessity of the presenting problem.
- Conduct documentation spot audits every three months.
- Track all high level encounters.

In the Event Of An Audit

- Show your compliance plan.
- Make it clear that everyone has been trained.
- Make it clear that you are using a scoring system for MDM.
- Show that you have a policy against cloning.
- Ensure the frequency of office visits is not excessive for a given condition.
- Make it clear that you understand the role of medical necessity.
- Show examples of how medical necessity is implemented in your clinic.
- Show the auditors a ranking list of diseases for your specialty. An example is the Consensus on Severity for Ocular Emergency: The Basic SEverity Score for Common Ocular Emergencies [BaSe SCORE] and how it’s used to determine services and level reported.
Questions?

Jeffrey Restuccio, CPC, COC, MBA
Memphis TN
(901) 517-1705
jeff@Ritecode.com
www.Ritecode.com

Additional Information

• Noridian Audit comments relevant to Medical Necessity.
• They would be amusing if not so common.
Medical Review Documentation Findings

- **Noridian Part B** Medical Review has noticed that many patient records submitted for review contain nonsensical and/or incomplete documentation, suggesting that they have not been reviewed by the provider at the time of preparation or prior to submission upon the contractor's request. **Medical notes must be comprehensible and legible.**

- The primary purpose of medical documentation is to ensure that the patient's treatment is recorded for the continuity of appropriate treatment by the attending provider(s). It is also important for colleagues, consultants, and office staff as well as other third parties that the notes are written legibly or are typed. Nonsensical and/or incomplete documentation increases the potential of legal implications for a provider.

Noridian comments

- Credit for services rendered cannot be granted if the medical record is incomplete. Additionally, the use of some software programs produces office notes that are nonsensical. Below are some examples of office notes submitted for medical review containing incomplete and/or nonsensical documentation.

  Excerpt from exam portion of E&M:
  - "His liver alert and oriented x3 shows a deficit of cognitive function are thought physical psychosomatic eye pupils equal and rectal exams are normal her eczema with inflammation".
Noridian Audit Excerpts

from exam portion of E&M
- "His liver alert and oriented x3 shows a deficit of cognitive function are thought physical psychosomatic eye pupils equal and rectal exams are normal her eczema with inflammation".

from HPI portion of E&M:
- "She states her back is doing much better she’s and Lipitor she has no hip or bone pain which has an infected tooth mesh for which she is on penicillin (Augmentin) as well as chlorhexidine mouth wash there thinking it may be due partially to the radio which she's not had a shot for some time now"
- "She has insomnia-she takes her temazepam at HS-she is gestating at least 5 hours at night"
- "He is needing a letter for his Shuttle service-he is needing it-he is wheelchair borne-he has weakness of the" [abruptly ends]

Noridian Audit Excerpts

- "She is here waiting for her schedule to see Dr. X (cardiology) for her heart and her ankle edema which is scheduled on March 30th. He has been causing apnea-with Dr. Y soon as well."
- "He still lives alone and cooks for himself. He gets his meds prepared weekly for him at Nicholson's"
- In the first two examples listed above, it is very hard to tell what exam items to give credit to for this patient. When notes are provided with no punctuation the thought process is hard to follow. Notes must be proofread before your electronic signature is applied. Signatures are verifying the notes are accurate, complete and without omission.
Documentation Software Templates

- Noridian Part B MR has noted that some Electronic Medical Record (EMR) software programs auto-populate certain aspects of the medical record with information that is not patient specific. This issue is more profound in the HPI when discussing the context of a certain illness and/or co-morbidity.
- Documentation to support services rendered needs to be patient specific and date of service specific. These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis.
- However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Part B MR is seeing the same auto-populated paragraphs in the HPI's of different patients. Credit cannot be granted for information that is not patient specific and date of service specific.

Jeffrey Restuccio, CPC, COC, MBA
Memphis TN
(901) 517-1705
jeff@Ritecode.com
www.Ritecode.com
# Medical Decision Making Criteria

**Decision Making:** There are four recognized levels of medical decision making: Straight Forward; Low Complexity; Moderate Complexity; and High Complexity; each with three components. Use the following 3 tables to determine the level of medical decision making documented in the medical record.

## Components

<table>
<thead>
<tr>
<th>Must meet or exceed 2 of 3 components below</th>
<th>Straight Forward</th>
<th>Low Complexity</th>
<th>Moderate Complexity</th>
<th>High Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of Diagnosis or Management Options (see table 1)</td>
<td>1 (minimal)</td>
<td>2 (limited)</td>
<td>3 (multiple)</td>
<td>4 (extensive)</td>
</tr>
<tr>
<td>2. Amount and/or Complexity of data to review (see table 2)</td>
<td>0 - 1 (none or minimal)</td>
<td>2 (limited)</td>
<td>3 (moderate)</td>
<td>4 (extensive)</td>
</tr>
<tr>
<td>3. Risk of Complications and/or morbidity or mortality (see table 3)</td>
<td>Minimum</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

### Table 1 / Diagnosis and Management

<table>
<thead>
<tr>
<th>Type of Problem</th>
<th>Determination Method</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited or minor</td>
<td>1 for single problem or 2 if the patient has two or more minor problems</td>
<td>1 or 2</td>
</tr>
<tr>
<td>Established: previously diagnosed</td>
<td>+ 1 for each additional problem previously diagnosed and addressed on current visit</td>
<td>1 ea.</td>
</tr>
<tr>
<td>Previously unidentified or undiagnosed, H &amp; P provide enough information</td>
<td>Maximum score is 3 for problems of this type, no matter how many are identified on visit</td>
<td>3</td>
</tr>
<tr>
<td>Previously unidentified or undiagnosed, you order or plan to perform additional assessment, consultation or diagnostic studies</td>
<td>One problem of this type qualifies as extensive</td>
<td>4</td>
</tr>
</tbody>
</table>

**Element Value Totals:** 1 = minimal, 2 = limited, 3 = multiple, 4 = extensive

### Table 2 / Amount and/or Complexity of Data to be Reviewed

<table>
<thead>
<tr>
<th>Data Information</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more lab tests requested or reviewed (CPT codes 80002 - 89299)</td>
<td>1</td>
</tr>
<tr>
<td>One or more radiology tests or services requested or reviewed (CPT codes 70010 - 79999)</td>
<td>1</td>
</tr>
<tr>
<td>One or more diagnostic studies requested or reviewed (CPT codes 90780 - 99199)</td>
<td>1</td>
</tr>
<tr>
<td>Direct visualization and independent interpretation of a specimen, image or tracing previously interpreted by another physician</td>
<td>2</td>
</tr>
<tr>
<td>Discussion of results with the physician who performed or interpreted a study</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or additional history</td>
<td>1</td>
</tr>
<tr>
<td>Summary of review of old records and/or additional history to supplement information from the patient</td>
<td>1</td>
</tr>
</tbody>
</table>

**Element Value Totals:** 1 = minimal, 2 = limited, 3 = multiple, 4 = extensive

### Table 3 / Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting Problems</td>
<td>One self-limited or minor problem, e.g. cold, insect bite, tinea corporis</td>
<td>Two or more self-limited or minor problems</td>
<td>One or more chronic illnesses with mild exacerbation, progression or side effects of treatment</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
</tr>
<tr>
<td>Diagnostic Procedures</td>
<td>Lab tests requiring venipuncture</td>
<td>Physiologic tests not under stress, e.g. pulmonary function tests</td>
<td>Physiologic tests under stress, e.g. cardia stress test, fetal contraction-stress tests</td>
<td>Cardiovascular imaging studies with contrast with risk factors</td>
</tr>
<tr>
<td>Management Options</td>
<td>Rest</td>
<td>Over the counter drugs</td>
<td>Minor surgery with no risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no risk factors</td>
</tr>
</tbody>
</table>

### Key points to remember about Medical Decision Making (MDM)

1. Only two of the three tables above need to be considered when determining which level of MDM you have achieved.
2. Always select the elements that will give you the highest acuity.
3. Any problem you evaluate that was previously undiagnosed or unidentified is considered a MODERATE level if no additional studies are needed after your H&P. If additional exams, tests, studies or consults are needed, it is a HIGH level acuity in Table 1.
4. Select the highest acuity element from the table of risk (Table 3 above) that is appropriate for your patient encounter, then from one of the other two tables, determine which element(s) you have identified/performed that determine the highest level of MDM.