Medical Necessity

Shannon DeConda, CPC, CPC-I, CEMC, CMSCS, CPMA, CPMN, CMPM

What is Medical Necessity?

• Medical appropriateness
• Medical complexity
• Why the provider did what he did

Why Does Medical Necessity Matter?

• “Overarching” determining factor
• The newest defining factor for audit analysis
• Brought on by EMR
Assumption of Medical Complexity

- Complications with medical necessity arrive when providers insist that it should be “assumed” that a test “should have been ordered”
- DO NOT ASSUME OR INTERPRET!!
- The provider of the medical care is responsible for connecting the dots
- CMS states the provider should “paint a portrait”

How does Medical Necessity affect Documentation?

- They must work together to support the same level
- What if:
  - Documentation = 99213
  - Medical Necessity = 99215
- What if:
  - Documentation = 99215
  - Medical Necessity = 99213

WARNING!! DISCLAIMER!!

- This session is NOT designed to promote creation of documentation which over enhances the services to yield a higher level of E&M service code.
- This presentation is meant to demonstrate the need for medical necessity in documentation
- Expose the work the provider is performing, but not always getting credit for through audit review
### PATIENT LEVELS OF SERVICE

#### Chronic Problems

- **Self Management Problem**
  - *Level 2*: Minimal Follow-up

- **Stable**
  - *Level 3*:
- **Mild Exacerbation**
  - *Level 4*:
- **Severe Exacerbation**
  - *Level 5*:

#### Acute Problems

- **Release From Care**
  - *Level 2*: Minor problem patient could have treated themselves

<table>
<thead>
<tr>
<th>Complication</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complicating Factor Present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complication Posing Threat to Life/Bodily Function</td>
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</table>
Is There a Difference in Medical Necessity and Medical Decision Making?

• Medical necessity is the overall analysis of the complexity of the full episode
• Medical decision making is merely a documentation audit process --- a “bean counting” process
Medical Necessity

- So this suggests that medical necessity differs from medical decision making and documentation guidelines
- Why do we use the first column in the table of risk?
- Do the other components of medical decision making not matter?

Scoring the Medical Necessity

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Minimal</td>
</tr>
<tr>
<td>99202</td>
<td>Low</td>
</tr>
<tr>
<td>99203</td>
<td>Moderate</td>
</tr>
<tr>
<td>99204</td>
<td>High</td>
</tr>
<tr>
<td>99205</td>
<td>Extraordinary</td>
</tr>
<tr>
<td>99206</td>
<td>Extreme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>One self-limited or minor problem, e.g. cold, insect bite, Tinea Corporis</td>
</tr>
<tr>
<td>99212</td>
<td>Two or more self-limited or minor problems</td>
</tr>
<tr>
<td>99213</td>
<td>One stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cancer, ARF</td>
</tr>
<tr>
<td>99214</td>
<td>Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain</td>
</tr>
<tr>
<td>99215</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
</tr>
<tr>
<td>99216</td>
<td>Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
</tr>
<tr>
<td>99217</td>
<td>An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss</td>
</tr>
<tr>
<td>99218</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
</tr>
<tr>
<td>99219</td>
<td>Two or more stable chronic illnesses</td>
</tr>
<tr>
<td>99220</td>
<td>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
</tr>
<tr>
<td>99221</td>
<td>Acute illness with systemic symptoms, e.g. peritonitis, pneumonia, sepsis</td>
</tr>
<tr>
<td>99222</td>
<td>Acute or chronic injuries, e.g. heat injury with blisters or superficial burns</td>
</tr>
</tbody>
</table>

Scoring the Medical Necessity
How does an auditor evaluate the medical necessity of the record?

BREAKDOWN THE RECORD

Breakdown what’s in the Documentation

- History
  - HPI
  - ROS
  - PFSH
- Exam
- Medical Decision Making
  - Number of diagnoses
  - Amount and complexity of data
  - Table of Risk

What does the history tell us about the patient?

Chief
Complaint

HPI- Symptoms caused by the HPI

ROS- How the body is affected systemically

PFSH- Historical information that may affect treatment or that may be affected by treatment
History of present illness
- Location – where is it (pain in left leg)
- Quality – how does it feel (achy, burning, radiating, numb etc.)
- Severity – how bad is it (1 – 10)
- Duration – how long (3 days ago)
- Timing – when does the symptom occur (it is constant or it comes and goes)
- Context - what happened to cause it (lifted a large object at work)
- Modifying factors – what did the patient do in an attempt to alleviate their symptoms (it is better when heat is applied)
- Associated signs and symptoms – what else is bothering the patient (numbness)

Exam Documentation
- Although required through documentation content it’s value to medical necessity is not as great as the history documentation is
- Exam is the tool used by the provider to “figure out” the severity of the patient
- Could it have more value to the auditor?
Medical Decision Making

• Synonymous Terms Include
  – Plan of care
  – Assessment and plan

• The way the plan is documented creates great impact on the overall severity associated with the encounter

Medical Decision Making

• These 3 components help define the providers analysis

  - Number of Diagnosis
    • New to the provider
    • Established to the provider

  - Complexity of Data Ordered or Reviewed
    • Points for reviewing test and or records
    • Points for ordering tests

  - Table of Risk
    • Assigning the overall risk of patient care based on the full analysis of the patient

Medical Decision Making

• All help to identify the level of severity according the provider and his/her analysis

  - Number of Diagnosis
    • New to the provider
    • Established to the provider

  - Complexity of Data Ordered or Reviewed
    • Points for reviewing test and or records
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  - Table of Risk
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Let’s Practice

• The following are scenarios that include documentation typically noted in a medical record.
• Let’s review and analyze the documentation for open discussion.

Established Patient Encounter Billed as 99214

• Patient presents to office for elbow pain with noted swelling. She has taken Advil and the pain has been present for quite some time now.

Is the problem Acute or Chronic?

Which Elbow? Left or Right?

Swelling, is that a new problem?

Is the problem stable or improved?

How much and how frequent is the Advil?

Example #1
Established Patient Encounter Billed as 99214

• Patient presents to office for RIGHT elbow pain with NEW ONSET OF noted swelling. She has taken 4 Advil UP TO 3-4 TIMES PER DAY and the pain has been present for quite some time now.

WORSENING THE LAST 2 WEEKS.

Is the problem Acute or Chronic?

Which Elbow? Left or Right?

Swelling, is that a new problem?

Is the problem stable or improved?

How much and how frequent is the Advil?
Compare the Historical Information

- Patient presents to office for elbow pain with noted swelling. She has taken Advil and the pain has been present for quite some time now.

Compare the Historical Information

- Patient presents to office for **RIGHT** elbow pain with **NEW ONSET OF** noted swelling. She has taken 4 Advil **UP TO 3-4 TIMES PER DAY** and the pain has been present for quite some time now **WORSENING THE LAST 2 WEEKS**.

Review of Systems

- **Eyes**: Normal
- **ENT**: Normal
- **Resp**: Normal
- **Cardio**: Normal

What does this **ROS** tell us about this patient?

**Chief Complaint**

**HPI**: Symptoms caused by the HPI

**ROS**: How the body is affected systemically

**PFSH**: Historical information that may affect treatment or that may be affected by treatment.
Review of Systems

• Eyes: Normal
• ENT: Normal
• Resp: Normal
• Cardio: Normal

99214 requires 2-9 Organ systems on review
How does this affect the medical necessity of answering the questions of the patient’s severity according to the patient?

Modifying the Review of Systems

• Patient presents to office for right elbow pain with new onset of noted swelling. She has taken 4 Advil up to 3-4 times per day and the pain has been present for quite some time now with worsening in the last 2 weeks.

The patient has no complaints of the elbow pain having any characteristics of numbness or tingling, reports pain from full flexion, no fevers, no changes in sleep pattern due to pain, and essentially negative effects to all other organ systems at this time.

Past Family Social History

• Can changing the way these elements are documented truly affect the complexity of the patient encounter?
• How many auditors simply check a box that it is there or not there and then move on?
• Consider this…. Our current patient is being seen for elbow pain. Let’s manipulate the PFSH
Past Family Social History

- Past Medical History: Negative for DM
- Family History: Negative for DM
- Social History: No Smoking/Drinking

What does this PFSH tell us about the medical complexity associated with this patient? Let’s see what a PFSH specific to the patient encounter would look like and how it would affect the level of service.

Past Family Social History

- Past Medical History: No previous elbow injuries or arthritis to the area
- Family History: Negative for RA
- Social History: Athletic playing racquetball weekly

Does this PFSH support the same level of documentation components as the previous PFSH supported? Does this PFSH better show the complexity and medical necessity associated with this patient’s care?

Exam

- How can the exam affect the medical necessity?
  - More of a tool, but can be defining
  - Negative for...
  - Normal
  - Specific information
  - Interpretation of the findings
Exam

This encounter was billed as a 99214, so TRULY how many organ systems were required?

- GENERAL: well developed and nourished; appropriately groomed; in no apparent distress;
- EYES: EOMI; PERRLA; normal lids, conjunctiva, and fundoscopic exam;
- E/N/T: normal EACs, TMs, nasal/oral mucosa, teeth, gingiva, and oropharynx;
- NECK: supple, full ROM; no thyromegaly; no carotid bruits;
- RESPIRATORY: lungs clear to auscultation and percussion; symmetric expansion; no dyspnea;
- CARDIOVASCULAR: regular rate and rhythm; normal SL, S2; no murmur, rub, or gallop;
- GASTROINTESTINAL: nontender, nondistended; no hepatosplenomegaly or masses; no bruits;
- GENITOURINARY: no adenopathy in cervical, supraclavicular, axillary, or inguinal regions;
- BREAST/INTEGUMENT: skin: no significant rashes or lesions; no suspicious mole;
- MUSCULOSKELETAL: normal gate, range of motion, strength and tone; elbow tender to palpation;
- NEUROLOGICAL: cranial nerves, motor and sensory function, reflexes, and coordination are all intact;
- PSYCHIATRIC: appropriate affect and demeanor; normal speech pattern; grossly normal memory;

What could the provider have changed in the exam documentation to show more medical complexity?

Plan of Care

• Elbow Osteoarthritis
Patient should continue current meds and return to clinic in one month for follow up.

What are the current meds? Assume the problem is stable?

Plan of Care

• Elbow Osteoarthritis
Patient should continue current SCRIPT OF MOBIC 5mg BID and return to clinic in one month for follow up. UPON RETURN, IF THE ELBOW IS NOT IMPROVED, WE WILL CONSIDER NERVE CONDUCTION STUDIES AND FURTHER IMAGING NEEDS. PATIENT SHOULD ELEVATE AND ICE PER SWELLING.
Whether Chronic or Acute—Score the Patient’s Newly Defined Medical Necessity

Medical Necessity

- Walk up the complexity...
- Having trouble understanding where level range it should fall?
- Having trouble teaching a provider how to assign their levels?
- WALK UP THE COMPLEXITY!!

Let’s walk the condition up the Acute Scale
Let’s walk the condition up the Chronic Scale

Medical Necessity vs. ICD-10

• Give it some thought?
  – Will they affect one another?
  – Can you use medical necessity to set the stage for successful ICD-10?
  – Need a scape goat????

Questions?