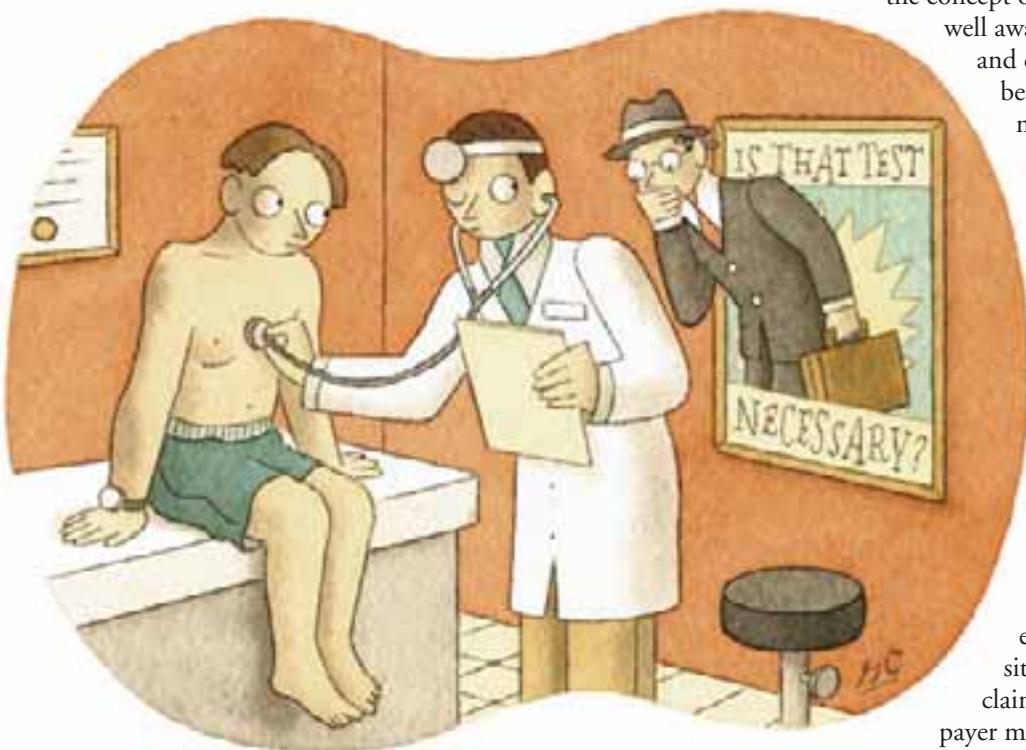


Reviewing the rules and examining your coding practices
can decrease denials and help you get paid.

A Refresher on MEDICAL NECESSITY

Peter R. Jensen, MD, CPC

At some point in our careers, most of us have received a denial from a health plan claiming that we performed a service that wasn't "medically necessary." This is a frustrating experience. After all, who is more knowledgeable about our patients' medical needs than we are? We understand the concept of medical necessity and are well aware that invasive procedures and diagnostic studies should be performed only when medically necessary. But sometimes medical necessity is harder to discern. Every so often, it's a good idea to brush up on the rules about medical necessity and consider how they relate to our coding habits. A quick review may help us to avoid unnecessary denials.



What does it mean?

Medicare and private payers recognize medical necessity as a deciding factor for claims payment. Though each payer might have its own definition, the overall themes are similar.

According to section 1862(a)(1)(A) of the Social Security Act, Medicare will not cover services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

The AMA's Model Managed Care Contract, a sample contract to help physicians negotiate with health plans,

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suggests this definition of medically necessary services: “Health care services or procedures 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; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider.”

The definitions of medical necessity are important, but it’s how they get applied in the claims adjudication process that gives them shape, particularly where evaluation and management (E/M) services are concerned. Here’s what the *Medicare Claims Processing Manual* says about the issue: Medical necessity 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.”

In other words, when it comes to selecting the appropriate level of care for any encounter, medical necessity trumps everything else, including the documentation of history, physical exam and medical decision making as outlined in Medicare’s *Documentation Guidelines for Evaluation and Management Services*. For physicians this could mean that even “bul-

let-proof” documentation of these key components will not ensure protection if auditors find that the medical necessity is lacking.

Applying the rules

The best way to stay within the bounds of medical necessity is to think of each element of the history and physical exam as a separate procedure that should be performed only if there is a clear medical reason to do so. For example, if you see an established patient who complains of intermittent chest pain, it would be medically necessary to perform a comprehensive history to address this issue. Each component of the history would yield clinically relevant information. First, you would take an extensive history of the present illness (HPI) to further describe the chest pain. Then you would ask about the patient’s past medical history to identify potential risk factors for coronary artery disease such as hypertension or dyslipidemia. You would also ask about family history of cardiovascular disease and perform a social history to determine if the patient is a smoker or has a sedentary lifestyle. Finally, because the spectrum of differential diagnoses for this problem is so broad, you would be justified in performing a complete review of systems (ROS) to uncover clues that may point you in the right direction.

The same logic applies to performing a comprehensive physical exam on this patient. Because the etiology of the chest pain is unknown, sound medical practice would dictate that a comprehensive exam be performed to help guide diagnosis and treatment.

On the other hand, when the same patient returns to your office for a follow-up visit six months after coronary artery bypass surgery with no specific somatic complaints, you would have a hard time justifying doing either a comprehensive history or exam. The information obtained would not be probative or clinically informative and therefore not within

■ Reviewing the rules of medical necessity can help you avoid unnecessary denials.

■ Even careful documentation of an encounter will not protect you from an audit if you cannot prove a service was medically necessary.

■ Before you perform certain elements of the history and exam, make sure they are relevant to the problem.

About the Author

Dr. Jensen is a practicing physician, reimbursement consultant and founder of EMUniversity.com, a Web site devoted to physician-to-physician E/M coding education. Author disclosure: nothing to disclose.

the bounds of medical necessity. In general, if you feel silly asking a question during the history or performing elements of physical exam, it probably means you have wandered off the path of medical necessity.

■ The level of complexity of your medical decision making will guide you to reasonable and necessary care.

Medical decision making and medical necessity

To ensure that the level of care you select matches the intrinsic medical necessity of the encounter, let the key component of medical decision making be your guide. Because it is based on the number and nature of the clinical problems as well as the risk to the patient, the complexity of your medical decision making may be a reliable surrogate for the vaguely defined concept of medical necessity. I usually estimate the medical decision making early in the encounter before I even start to document the history and exam. I then let the medical decision making point me toward what I think will be the appropriate code. I perform and document only those elements of history and exam that are necessary to take good care of the patient. If my final history and exam fulfill the requirements for the code I had in

■ When medical necessity prompts you to perform a preventive service and a problem-oriented E/M service on the same day, document your care thoroughly and append modifier -25 to the E/M code.

SAME-DAY PREVENTIVE AND E/M SERVICES

Sometimes it is medically necessary to perform a preventive medicine service and a problem-oriented E/M service on the same day. Some payers bundle these services, but others will reimburse for both, in keeping with the CPT definitions. For example, if you are performing an annual physical and discover that the patient has a significant medical problem that needs to be addressed, medical necessity would compel you to perform and document a separate E/M service to deal with the patient's complaint. Your documentation of the problem should include a chief complaint, history of present illness, review of systems and examination of the related body areas/organ systems as appropriate. You would bill separately for the annual physical and the E/M service, appending modifier -25 to the E/M code to indicate that you provided a significant, separately identifiable E/M service on the same date.

Conversely, if a patient comes in for an annual physical and, during the course of the visit, you address a chronic condition that is controlled, it would not be medically necessary to perform a significant, separate problem-oriented E/M service to address it. This service would be considered part of the preventive service. (For more information about performing an E/M service and a preventive service on the same day, see "Same-Day E/M Services: What to Do When a Health Plan Won't Pay," *FPM*, April 2006.)

mind, then this is the code I bill. When my documentation falls short of the requirements for this code, I use a lower level code.

The importance of diagnosis coding

ICD-9 codes represent the first line of defense when it comes to medical necessity. Correctly chosen diagnosis codes support the reason for the visit as well as the intensity of the E/M services provided. Here are four strategies to incorporate into your diagnosis coding habits:

1. Link each ICD-9 code to the appropriate CPT code. On your claim forms, make sure it's clear which diagnosis codes correspond with which services. This will show health plans why it was medically necessary for you to perform the services you did.

2. Include a fourth or fifth digit to more accurately describe your patient's condition. Consider a patient with chronic obstructive pulmonary disease (COPD) that is not controlled on current inhalers. You decide to add a steroid inhaler to current therapy with a beta-2 agonist. You could report the encounter using only the ICD-9 code for COPD, 496, "chronic airway obstruction, not elsewhere classified," but a more descriptive approach would be to code 491.21, "obstructive chronic bronchitis with acute exacerbation." This code specifically identifies the patient as having some elements of chronic bronchitis, COPD and emphysema, and indicates that these clinical problems are not controlled.

3. List all appropriate ICD-9 codes, beginning with the primary diagnosis. The standard billing form for Medicare has room for four ICD-9 codes to describe the encounter. When appropriate, you should fill all four slots. The code that describes the primary diagnosis or reason for the visit should appear first, followed by codes for other diagnoses listed in descending order of importance. Choose the codes that best describe the context and severity of the clinical problems you addressed, keeping in mind that "suspected" or "probable" diagnoses should always be omitted.

For example, let's say you are submitting a claim for a level-V office visit (99215) and the only ICD-9 code you report is for congestive heart failure (428.0). You can guarantee that this encounter will be scrutinized in terms of

ICD-9 codes represent the first line of defense when it comes to medical necessity.

medical necessity. However, consider reporting the same CPT code with the following four ICD-9 codes:

- 428.23, acute on chronic systolic heart failure ;
- 786.02, orthopnea;
- 276.1, hyposmolality and/or hyponatremia;
- 782.3, edema.

These codes would convey the information that the encounter took place to treat orthopnea due to an acute exacerbation of chronic systolic congestive heart failure and that the patient also had hyponatremia and edema.

4. Learn which codes you use together most frequently. There are certain codes that convey information in clusters. These code sets are often used to describe common clinical problems that frequently occur together. For instance, in my specialty of nephrology, I often use the following code set:

- 250.42, diabetes with renal manifestations; type 2 or unspecified type, uncontrolled;
- 585.4, chronic kidney disease, stage IV (severe);
- 791.0, proteinuria;
- 285.21, anemia in chronic kidney disease.

The first code is a “power code” that signifies that the patient has type-2 diabetes mellitus that is poorly controlled and has led to renal insufficiency. The other codes explain that this has led to severe renal compromise to the point where the patient has lost between 71 percent and 85 percent of his or her glomerular filtration rate. They also show that the patient has proteinuria and renal anemia.

I feel far more comfortable submitting a level-IV or level-V office visit for these codes than for the single code 593.9, “unspecified disorder of kidney and ureter.”

For another example, consider a patient with diabetes, open wounds of the toes and no pedal pulses. You might code the following:

- 250.80, diabetes with other specified manifestations;
- 250.70, diabetes with peripheral circulatory disorders;

- 707.15, ulcer of toes;
- 443.81, peripheral angiopathy.

The bottom line is this: If you are taking care of multiple clinical issues during an encounter, make sure this is reflected in your ICD-9 coding.

NCDs and LCDs

In addition to implementing the preceding diagnosis coding strategies, you also need to be aware of Medicare’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs, formerly known as Local Medical Review Policies, or LMRPs). These rules specify the services that are allowed for certain diagnoses. NCDs are Medicare’s standard, national rules; LCDs are local carriers’ versions of NCDs. Medicare carriers’ databases screen your CPT/ICD-9 coding pairs to make sure they are in line with LCDs and automatically deny those that are not. Because LCDs don’t exist for all services and focus primarily on diagnostic tests, many claims aren’t affected by this screening.

In the event that you feel a service is important even though it may not be covered by Medicare, consider asking your patient to sign an Advance Beneficiary Notice. This will enable you to bill the patient for the service.

LCDs can change frequently, causing

By linking ICD-9 and CPT codes correctly, you show payers why you performed the services you did.

Using a fourth or fifth digit in your diagnosis codes provides a more specific description of your patient’s condition.

Always report each appropriate diagnosis on your billing form, beginning with the primary diagnosis.

APPEALING A DENIAL

Sometimes it’s appropriate to appeal a health plan denial. Knowing when and how to appeal will help you make the most of your time and effort. Before you appeal, make sure you understand your patient’s coverage, the health plan’s requirements and your state and federal regulations. These *FPM* articles offer advice and instruction on negotiating the appeals process:

“Precertification, Denials and Appeals: Reducing the Hassles.” Akosa AN. June 2006;45-48.

“Making Sense of Health Plan Denials.” Bare J. June 2001;39-44.

“Navigating the Patient Appeals Process.” Moore KJ. October 2000;43-46.

frustration for physicians. To keep as up-to-date as possible, check the Medicare Web site at <http://www.cms.hhs.gov/mcd/search.asp>?. You may choose to search for both NCDs and LCDs by checking both boxes in the first section of the search page.

■ To avoid automatic denials, check Medicare's Web site for your carrier's local coverage determinations.

Private payers can create their own rules when it comes to allowing certain services with certain diagnoses. Most payers post their determinations on their Web sites.

The pros and cons of EHRs

■ EHR users shouldn't rely solely on the system's suggestions when choosing what level of service to code.

Some electronic health record (EHR) systems may have the ability to tell you what level of service your documentation supports. However, computer systems will never be able to mimic the judgment and insight necessary to accurately assess medical necessity. Software programmers look at the E/M guidelines as a simple algorithmic rule set that may be manipulated to automatically produce a predetermined result. For example, an office visit with an established patient requires qualifying documentation of only two out of three key components. Therefore, a physician using an

EHR system could theoretically qualify for level-IV visits (99214) by simply documenting a detailed history and a detailed exam all the time. Some of the more sophisticated programs even provide cues for physicians to "add one more bullet" or "do one more review of systems" to qualify for incrementally higher levels of care. If you're not careful, this could lead to a pattern of coding and documentation that would not pass muster when it comes to medical necessity.

A necessary reminder

While it's important not to lose sight of the role of medical necessity in the coding and documentation process, try not to let this awareness lead you to underestimate the value of your cognitive labor. Let medical necessity guide the care you provide, document that care accurately and code based on your documentation. This will help ensure fewer claims denials and appropriate care for your patients. **FPM**

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