Medical Necessity: Avoid Costly Audits

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Risk

- Every patient encounter has risk associated
  - ✓ Provider
  - ✓ Medical Assistant
  - ✓ Coder
  - ✓ Biller
  - ✓ Practice Manager
  - ✓ Entire Practice
- Risk of:
  - ✓ Liability case for medical practice
  - ✓ Liability of negligence
  - ✓ Fraud and/or abuse
  - ✓ Allegation of provider misconduct

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Risk

- Medicare contributes a portion of clinic only payment towards malpractice. Clearly, not enough!
- Other Liability
  - ✓ False Claim Penalties
    - Triple the claim amount
    - Civil Monetary Penalty
    - Jail and/or $25 thousand

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Risk

- False Claims Act Breakdown

32 Patients/Day	$73.00 per patient	$2336 in daily claims
Triple the claim	$219.00/claim	$7008 penalty
Penalty fee	Average	$8520 average penalty
Additional	Monetary Penalty	$25,000 and/or jail
One day of work just cost $40,258 +/- jail time		

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Let's Get Started

- The previous risk discussed helps to understand the basis of this session.
- Understand the different types/views of documentation
  - ✓ Be a better teacher
  - ✓ Defensive documentation

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 SLIDE 5

Documentation

- Who creates documentation?
- Who codes the documentation?
- Who reviews the documentation?

- Do we all speak the same language?

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 SLIDE 6

Documentation

- Provider and office staff create the documentation
  - ✓ Provider believes the work involved supports 99214
    - What the provider believes and what is documented may vary SIGNIFICANTLY.
  - ✓ The coder reviewing the documentation agrees
    - The coder is utilizing an audit tool of which most do not include medical necessity.
  - ✓ A reviewer determines the code is 99213 based on medical necessity
    - The reviewer has been educated that medical necessity is the overarching determining factor when choosing an E&M level of service.

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 SLIDE 7

What is Medical Necessity?

- **Medical necessity** is defined as accepted health **care** services and supplies provided by health **care** entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of **care**.
- Can be defined as:
  - ✓ Medical appropriateness
  - ✓ Medical complexity
  - ✓ Why the provider did what he / she did
- Why did the provider have a face-to-face encounter with the patient today?

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 SLIDE 8

What is Medical Necessity?

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."

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Medical Complexity

- Do not assume or interpret
- The provider is responsible for documenting why additional services were ordered and/or treatment course was modified
- CMS states that the provider should "paint a portrait" of the entire encounter

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Amerigroup Corporation, acting on behalf of the Texas Health Plan, requested 50 medical records from your office in which CPT 99215 (Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient, Which Requires At Least 2 Of These 3 Key Components: A Comprehensive History, Comprehensive Exam, and High medical decision making) were reimbursed from a universe of claims for dates of service from March 3, 2011 through January 2, 2013. A medical records audit of your initially submitted claims **and** your rebuttal documents has been completed.

The medical records were reviewed by a Certified Professional Coder (CPC) and a Medical Director for verification of services and the validation of the appropriate level of care. The review results identified inaccurate billing for procedures 99215 based on the level of care documented in the medical records.

- The documentation appears to have been generated from an Electronic Health Record- as it is in an HTML format and many of the details are forwarded from previous dates of service. Documentation should address the reason for the patient's visit and any pertinent information from previous visits may be incorporated. However, it appeared that all information, (unrelated diagnosis, telephone calls, missed appointments, etc.) were in the daily note. This information was not used to determine the level of service rendered.
- All previous diagnoses were brought forward with no clear indication as to why it was in the present dates note.
- Review of Systems may have indicated review with no direct tie to the presenting problem, and no elaboration. No credit was given. Areas related to the presenting problem or chronic issue treated may be allowed.
- Exam elements may have indicated abnormal with no elaboration OR exam of body areas/systems with no relation to the chief complaint. All areas may not have been allowed.
- Recommendations appear to be cloned as they are the same for each record with few exceptions. All elements of the medical record should be patient specific, addressing issues related to the individual patient.

Providers Viewpoint

- As a provider who:
  - ✓ REALLY reviewed all of the information
  - ✓ REALLY did a complete and thorough evaluation with a very ill patient
  - ✓ Spent an hour and a half on a patient
  - ✓ Forced into using an EMR system that produces intense documentation
- It does make sense to bill for the maximum reimbursement!

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Coders Viewpoint

- As a coder who:
  - ✓ Has been taught to use the 95/97 guidelines
  - ✓ Utilizes an audit too that only gets check marks and points when the documentation is present
  - ✓ Was not taught the indications of medical necessity, as well as the scoring methodologies
- It makes sense to code for the maximum reimbursement!

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Trained Auditors Viewpoint

- Give this record to any seasoned, well trained auditor and they will agree that based on medical necessity, the visits are not 99215 regardless of:
  - ✓ The doctors work involved
  - ✓ The documentation bullets being satisfied to support 99215

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Common Areas of Concern

- Over documenting a level of service
  - ✓ Templates
    - Do not “carry forward” documentation unless it is pertinent to the presenting problem and has been reviewed
    - Inaccurate “default” documentation
  - ✓ Forms
    - If not performed, leave blank
- Providers and staff often disagree on what documentation was medically necessary for a visit.
  - ✓ Ask questions!!!!

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Templates/Forms

- History of Present Illness (HPI)
  - ✓ Pre-populated history of present illness
    - Review of records show that all 10 encounters reviewed had the same HPI, regardless of presenting problem
- Review of Systems (ROS)
  - ✓ Review of all 14 systems (most of which are not relevant and/or related to the presenting problem)
  - ✓ Check box with an indication “all other systems reviewed and are negative”
  - ✓ Example: 13 year old healthy male presents to the ED for a laceration caused when cutting an apple.

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Templates/Forms

- Auto-population of past medical, family and social history
  - ✓ Was this reviewed and is the information correct?
- Auto-population of examination
  - ✓ Does the provider always perform the same examination on every patient?
  - ✓ Are the findings always identical?
- Auto-population of medications (referenced)
  - ✓ This feature typically updates every time something is edited/changed/deleted.
- Inserting the patients current conditions into the assessment with no documentation to support that these conditions were addressed.

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Electronic Health Records (EHR)

- Some have the ability to tell you what level of service your documentation supports
  - ✓ Computer systems will never to able to mimic the judgment and insight necessary to accurately assess medical necessity.
- Some have the ability to provide cues for physicians to “add one more bullet” or “do one more review to systems” to qualify for incrementally higher levels of care
  - ✓ Caution…this could lead to a pattern of coding and documentation that would not pass when it comes to medical necessity.

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Medical Decision Making

- Also known as a plan of care or assessment and plan
- Documentation of the assessment/plan has a great impact of the overall severity associated with the encounter

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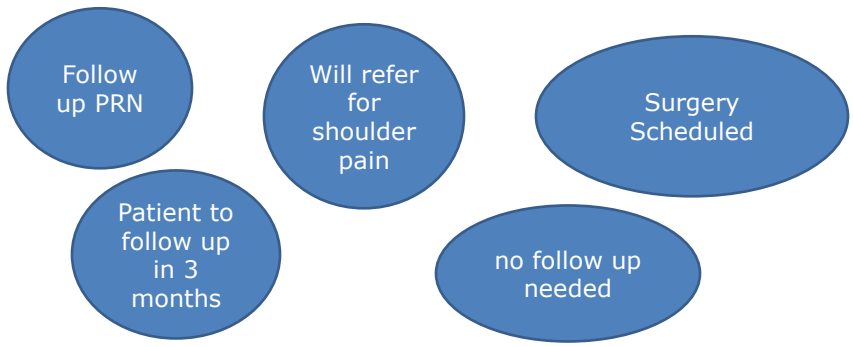
Medical Decision Making



The plan of care should document the thought process of the provider.

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Medical Decision Making

Coder's typically utilize an audit tool to determine medical decision making.

The auditor must utilize the following to define the level of medical decision making:

- *DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*
  - *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*
  - *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (R/O) diagnoses.*
- *DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*
- *DG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

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SLIDE 21

Medical Decision Making

- The Documentation Guidelines create the most controversy and confusion
  - ✓ Utilize the Table of Risk to assist with the determination of medical necessity

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SLIDE 22

Table of Risk

Level	Presenting Problem	Diagnostic Procedure	Management Options
Straight-forward	One self limited or minor problem, ie: cold, insect bite, tinea coporis	Lab test requiring venipuncture, chest x-ray, EKG/Eeg, Urinalysis, Ultrasound, KOH prep	Rest Gargles Elastic Bandages, Superficial Dressing
Low	Two or more self limited or minor problems One stable chronic illness Acute uncomplicated illness	Non-cardiovascular imaging study w/contrast Superficial needle biopsy Clinical laboratory test requiring arterial puncture Skin biopsy	Over the counter drugs Minor surgery w/no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	One or more chronic illnesses with mild exacerbation, progression or side effect of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms	Physiological tests under stress Diagnostic endoscopies w/no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging study w/contrast & no identified risk factor Obtain fluid from body cavity	Minor surgery w/identified risk factor Elective major surgery w/no identified risk factor Prescription drug management Therapeutic nuclear medicine IV fluids w/additives Closed treatment of fracture or dislocation w/o manipulation
High	One or more chronic illnesses w/severe exacerbation, progression or side effect of treatment Acute or chronic illness or injuries that pose a threat to life or bodily function An abrupt change in neurological status	Cardiovascular imaging studies w/contrast w/identified risk factor Cardiac electrophysiological tests Diagnostic endoscopies w/identified risk factors Discography	Elective major surgery w/identified risk factor Emergency major surgery Parenteral control substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

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The Effect of Medical Necessity on Documentation

- The documentation and medical necessity must work together to support the same level of service
- Medical necessity defines the complexity of the patient at that particular visit.

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Patient Presents with Acute Problem

99212	**Self limited, minor problem** **No follow up, no work up, really did not need to see provider**
99213	Acute uncomplicated problem Cough, fever, congestion
99214	Acute problem with complicating factors Cough, fever, congestion in a child with a history of asthma
99215	Acute problem with a threat to life or bodily function Cough, fever, congestion in a child with a history of asthma Severe wheezing with neb treatment and assessment for possible hospitalization

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Medical Necessity vs. Medical Decision Making

- Medical decision making is merely a documentation audit process
  - ✓ Audit tools utilize the point system for most of the medical decision making
- Medical necessity is the overall analysis of the complexity of the entire encounter

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Tips

- Think of each element of the history and physical exam as separate procedures that should be performed only if there is a clear medical reason to do so.
- 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 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.

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Not Just E/M Services

- Diagnosis Coding
  - ✓ Helps support the medical necessity of the procedure
    - Patient presents with left knee pain and the provider performs an arthrocentesis. The provider also orders a chest x-ray. The only diagnosis documented is knee pain. The knee pain supports the medical necessity for performing the arthrocentesis, but does not support the medical necessity for the chest x-ray.
    - Query the provider as to why the chest x-ray was ordered. Maybe the intent was to order a knee x-ray. Addend the documentation.
  - ✓ LCD's and NCD's
    - http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

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Not Just E/M Services – Diagnosis Coding

1. Link each ICD-10 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-10 code for COPD, J44.9, "chronic obstructive pulmonary disease, unspecified," but a more descriptive approach would be to code J44.1"chronic obstructive pulmonary disease 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.

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Not Just E/M Services – Diagnosis Coding

3. List all appropriate ICD-10 codes, beginning with the primary diagnosis. The standard billing form for Medicare has room for four ICD-10 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-10 code you report is for congestive heart failure (I50.9). You can guarantee that this encounter will be scrutinized in terms of medical necessity. However, consider reporting the same CPT code with the following four ICD-10 codes:

- I50.43, acute on chronic combined systolic and diastolic heart failure;
- R06.01, orthopnea;
- E87.1, hyposmolality and/or hyponatremia;
- R60.9, edema.

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

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Not Just E/M Services – Diagnosis Coding

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.

Many of the codes utilized in I-9 required several different codes to adequately detail the specific diagnosis.

With ICD-10, these codes are now included in one code. Ensure that you are utilizing the most descriptive code.

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Why does all of this matter?

- Medicare watchdogs are now looking back over records to determine if services were not medical necessary.
  - ✓ Medicare Administrative Contractors (MACs) and affiliated contractors
  - ✓ Zone Program Integrity Contractors and Program Safeguard Contractors
  - ✓ Recovery Audit Contractors (RACs)
  - ✓ Office of Inspector General
  - ✓ Comprehensive Error Rate Testing
  - ✓ Quality Improvement Organization

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Why does all of this matter?

- Most auditors have changed their "pattern" of auditing
  - ✓ Define the medical necessity first
  - ✓ THEN…make sure that the other components of the documentation "match up" to the level of medical necessity

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Why does all of this matter?

- Comprehensive Error Rate Testing (CERT)
- Calculates the Medicare Fee-for Service improper payment rate each year.
  - ✓ Valid random samples of claims taken to determine if they were paid properly under Medicare coverage, coding and billing rules.

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Why does all of this matter?

- The fiscal year (FY) 2014 Medicare FFS program improper payment rate is 12.7 percent, representing $45.8 billion in improper payments, compared to the FY 2013 improper payment rate of 10.1 percent or $36.0 billion in improper payments (1). The table below outlines the improper payment rate and projected improper payment amount by claim type for FY 2014. The reporting period for this improper payment rate is July 1, 2012 -June 30, 2013.

Service Type	Improper Payment Rate	Improper Payment Amount
Inpatient Hospitals	9.2%	$10.4B
Durable Medical Equipment	53.1%	$5.1B
Physician/Lab/Ambulance	12.1%	$11.0B
Non-Inpatient Hospital Facilities	13.1%	$19.2B
Overall	12.7%	$45.8B

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Why does all of this matter?

All Services	Insufficient Documentation Errors		
	Improper Payment Rate	Projected Improper Payments	95% Confidence Interval
Hospital Outpatient	7.3%	$3,305,285,183	4.2% - 10.5%
SNF Inpatient	5.2%	$1,844,226,232	3.6% - 6.8%
Hospital Visits-subsequent	11.2%	$633,004,222	9.3% - 12.7%
Office Visits – established	2.2%	$315,389,642	1.5% - 2.9%
Hospital Visit – initial	9.8%	$286,878,096	7.9% - 11.8%

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Why does all of this matter?

All Services	Incorrect Coding Errors		
	Improper Payment Rate	Projected Improper Payments	95% Confidence Interval
Office Visits-new	13.6%	$365,915,193	11.6% - 15.7%
Hospital Visits-subsequent	8.6%	$484,801,534	7.7% - 9.4%
Office Visits – established	2.2%	$315,389,642	1.5% - 2.9%
Hospital Visit – initial	20.8%	$607,210,694	19.1% - 22.5%
Emergency room visit	9.9%	$216,058,135	8.1% - 11.7%
Hospital Visit-critical care	13.7%	$138,376,437	10.5% - 17.0%

Why does all of this matter?

OIG Report (OEI-04-10-00181) 2010

Type of Error	Percentage of Claims for E/M Services	Medicare Payments (in Billions)
Incorrectly Coded	42.4%	$3.3
• Miscoded	40.4%	$2.8
• Upcoded	26.0%	$4.6
• Downcoded	14.5%	($1.8)
• Other Coding Error (wrong code, Unbundling)	2.0%	$0.5
Lacking Documentation	19.0%	$4.6
• Insufficiently Documented	12.0%	$2.6
• Undocumented	7.0%	$2.0

Why does all of this matter?

- In 2012, OIG reported that physicians increased their billing of higher level codes, which yield higher payment amounts, for E/M services in all visit types from 2001 to 2010. CMS found that E/M services are 50 percent more likely to be paid for in error than other Part B services; most improper payments result from errors in coding and from insufficient documentation

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What Can Be Done?

- Education is the key
  - ✓ Providers
    - New
    - established
  - ✓ Coders
  - ✓ Billers
  - ✓ Office extenders
  - ✓ Compliance

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What Can Be Done?

- ✓ Development of accessible lines of communication such as:
  - Discussion at staff meetings
  - Development and maintenance of a resource binder
  - Placement of an anonymous drop box for conveying issues
  - Establishment of a compliance bulletin board
- ✓ Enforcement of disciplinary standards

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What Can Be Done?

- A compliance program for a physician should include these seven elements:
  - ✓ Internal monitoring and auditing focusing on high risk billing and coding issues through performance of periodic audits
  - ✓ Compliance and Practice Standards
  - ✓ Designation of a Compliance Officer
  - ✓ Comprehensive training and education
  - ✓ Thorough investigation and appropriate response to detected violations and possible disclosure to the Federal Government

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Action Plan

- Audit consecutive patient visit notes and review what information may be automatically document in each note with little or no relevance or changes.
- Remove templates that contain information that would never have been documented prior to EHR use ("appears to be breathing")
- Investigate how the EHR was implemented and how providers were trained
- Review with staff how to document history and review of systems
- Conduct an internal audit (peer review) or contract with a consulting company.

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References

- http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2014ImproperPaymentsReport.pdf?agree=yes&next=Accept
- http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

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Questions?

Thank you!

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