Crash Course in Medical Necessity for E/M Coders

Stephanie Cecchini, CPC, CEMC, CHISP

About the Presenter

Stephanie Cecchini, CPC, CEMC, CHISP, is VP of Products at AAPC. Her passion is providing solutions that allow coders to help physicians to best pursue their hard-earned art in the practice of medicine. She is an executive level healthcare sales, operations, and public speaking expert with significant & broad ambulatory healthcare business experience with emphasis on multi-specialty physician groups and payers. She has served as a senior executive for over 15 years. In prior roles: as VP of Coding Operations with Aviacode, overseeing the coding operation of more than 30 million claims per year. As Chief Audit Officer for Parses, Inc, she assured physician medical coding audit accuracy & quality control for payer driven recovery audits of professional fees and was responsible for driving sales & managing new coding audit programs. Stephanie lives in Salt Lake City, Utah with her husband Jim and their three children. Stephanie is LION (Linked In Open Network). http://www.linkedin.com/in/StephanieCecchini

You

- Learn how to confidently code the correct E/M level ---every time
- Discover when documentation becomes a compliance problem
- Stop over-coding or under-coding claims based on Medical Necessity
- Gain an essential understanding of regulations that effect E/M documentation
- Combat today's most challenging E/M leveling errors with actionable info
- Learn 5 things every coder should do to accurately code for Medical Necessity

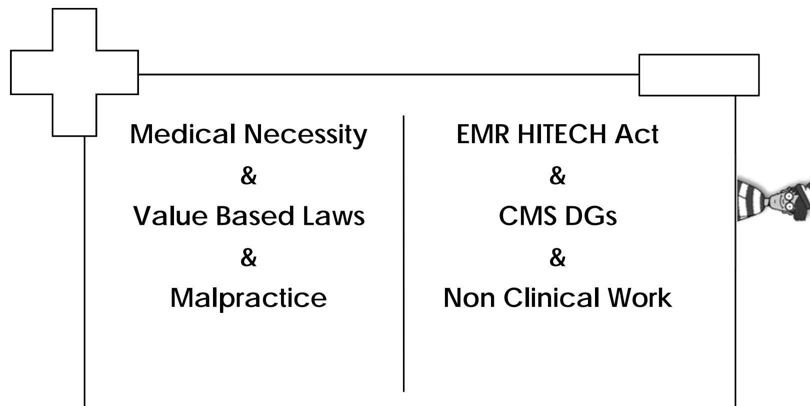
3

Drowning in Documentation.

Thousands of Pages in legalese

- Federal Register
- OIG Compliance Guidance
- ICD 10 Official Guidelines
- CMS.gov Internet-Only Manuals (IOMs)
  - ✓ Chapter 12 – Physicians
  - ✓ Medicare Claims Processing Manual
  - ✓ CMS Medicare Benefit Policy Manual
- CPT guidelines
- CMS 1995 and 1997 DGs for EM
- HIPAA
- CCI National Correct Coding Initiative (NCCI)
- False Claims Act and Qui Tam
- Social Security Act (Medical Necessity)

Mixed Messages & Documentation



The Truth In Soapy Coding

- Subjective: Opinions
  - Medical Necessity is a clinically required action
  - It is the reason for a service
  - It validates the provision of service
    - It is open for interpretation by all parties involved

Objective: Facts

- Medical Decision Making E/M Component is a measurement of work
  - It is defined by:
    - 1995 and 1997 Documentation Guidelines
    - Marshfield Clinic audit tool.
  - Medical Decision Making is the mathematically formulated result of all documented components of the physician's service, whether medically needed or not.
    - It is the data driven outcome of a patient visit and not a substitute for determining the appropriateness of the services rendered or the Medical Necessity.

$$e^{\Pi i} + 1 = 0$$

Assessment: Judgements

- The best way to stay compliant with Medical Necessity related laws is to think of each element of the patient's history and physical exam as a separate procedure that should be performed only if there is a clear medical reason to do so.
  - This requires making a clinical judgement.
  - A coder, while better educated than most non-clinicians, is not able to make that judgment with the certainty of a medical peer.

Plan: Strategies

- In an effort to bridge the gap between the clinical savvy of a documenting provider and a clinically untrained coder some coding administrators have exchanged the definition of
  - Medical Necessity with the MDM component of E/M services.
- This mistake can leave money on the table or result in overpayments.
- A different strategy is needed

The Medical Necessity Problem

- Incorrect E/M coding resulted in $1.4B in overpayments in 2015.
  - Problem code 99233 had a 50.4% error rate in 2015
  - Problem code 99214 had a 14.3% error rate in 2015
  - Problem code 99232 had a 16.5% error rate in 2015
- Medical Necessity errors are nearly twice as common as are coding errors.
- CMS 1995 and 1997 Documentation Guidelines are not statutes
  - Medical need for services rendered is the authoritative factor
    - Medical necessity is not defined

How is Medical Necessity Defined?

- Government:
  - Per the Social Security Act 42 U.S.C. § 1395y(a)(1)(A), “SSA” Medicare only pays for medical items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member", unless there is another statutory authorization for payment.
  - National coverage determinations (NCDs) and Local Coverage Determinations (LCDs). Section 522 of the Benefits Improvement and Protection Act (BIPA) defines an LCD as a decision by a Medicare carrier whether to cover a particular service in accordance with the SSA

AMA

- "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; and
- (c) not primarily for the convenience of the patient, physician, or other health care provider."

"Generally Accepted"

- What is common acknowledged as "generally accepted"?
  - Standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
  - Physician specialty society recommendations;
  - The views of physicians practicing in the relevant clinical area.

Evidence Based Guidelines

- Industry standard guidelines for evidence based determinations of Medical Necessity by payers include
  - MCG (formerly Milliman Care Guidelines)® by MCG Health LLC of the Hearst Health network, and
  - InterQual® by McKesson.
    - InterQual® provides a structure of criteria for "severity of illness (SI)" and "intensity of service (IS)" to help determine if a patient is sick enough to be admitted an inpatient.
- These standards are helpful insights, however are incomplete substitutes for the clinical judgment of the physician.

CPT® Nature of the Presenting Problem

Tools

- Minimal: A problem that may not require the presence of the physician or other qualified health care professional, but service is provided under the physician's or other qualified health care professional's supervision.
- Self-limited or minor: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- Low severity: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- High severity: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

MDM as a MN Driver?

Tools

- Example:
  - Number of Diagnoses and Management Options:
    - A patient with a new problem is diagnosed during the same encounter with a problem that is more severe than a minor problem. This is worth “3” on the MDM scale of Number of Diagnoses and Management Options.
  - Amount/Complexity of Data:
    - The physician ordered and reviewed a medical test in his office. This is worth “1” on the Amount and Complexity of Data
  - Overall Risk:
    - The problem requires a prescription medication, which the physician orders.

Clinically Stated

The patient has sudden central vision loss and is sent to a Retina specialist for diagnosis and treatment. A history is obtained and both eyes are thoroughly examined. Several optic tests are used, including an Amsler grid and optical coherence tomography. A new diagnosis is made by the physician of sub choroidal neovascularization for which he recommends a monthly injection of Avastin. He explains the risk of the injections, and shares with the patient the risk of continued vision loss with or without the injection. The patient elects to have the injection the same day. Follow-up in 3 weeks for evaluation and repeat injection.

MDM as a MN Driver?

MDM Medical Decision Making (2 of 3)

NUMBER OF DX and MANAGEMENT OPTIONS • Minor =**1 ea.** (max 2 points) • Est. stable/improved = **1 ea.** • Est. worsening =**2 ea.** • New problem(S), w/o workup =**3** • New problem, w workup=**4 ea.**	AMOUNT/COMPLEXITY OF DATA: <u>One Point Each:</u> • Clinical Labs test ordered or reviewed • CPT® Medicine Section Test- ordered/reviewed • CPT® Radiology Section Test- ordered/reviewed • Discuss patient results w performing / consulting Dr • Decision obtain old records or additional hx other than pt <u>Two Points Each:</u> • Review/summarize data old records/add hx other than pt • Independent interpretation of an image, tracing, specimen	**OVERALL RISK:** The quick reference guide below shows excerpts from the CMS Table of Risk. * Risk is based on the disease process anticipated between the present encounter and the next one.	Type	New or Est. Out Pt LEVEL
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4	4	**Clinical testing/management examples:** Cardiovascular imaging with risk factors, endoscopies with risk factors, discography, medication toxicity management, major surgery with risk factors, emergency surgery with risk factors, etc. **Presenting Problem Example:** 1+ chronic severely exacerbated / Illness or injury that poses a threat to life / Abrupt change in neurological status	H	5

19

Answer is a Level Four, right? Well…

- What if the patient was sent by the physician to be worked up at an outside facility, and the patient returned with the test results for final diagnosis with the results on the same day?
- What if the provider decides that the risk of the problem is not classifiable as that associated with Prescription drug management, but rather with the risk associated with an acute illness or injury that poses a threat to bodily function (in this case vision)?
  - In terms of code selection for Medical Necessity with an MDM driver, this could now support a Level Five new or established Outpatient patient.
- Another example: 45-year-old, otherwise healthy male returns for a non-resolved problem first seen 5 days ago ….a cough x 7 days which is now productive. This patient is also under the physician's care for well controlled hypertension and hypercholesterolemia. The diagnosis today is URI. She reviews all the patient's current medications and adds to it by ordering an antibiotic. No follow-up requested
  - MDM is moderate….is this a Level Four clinical example?

Five Secrets to Success

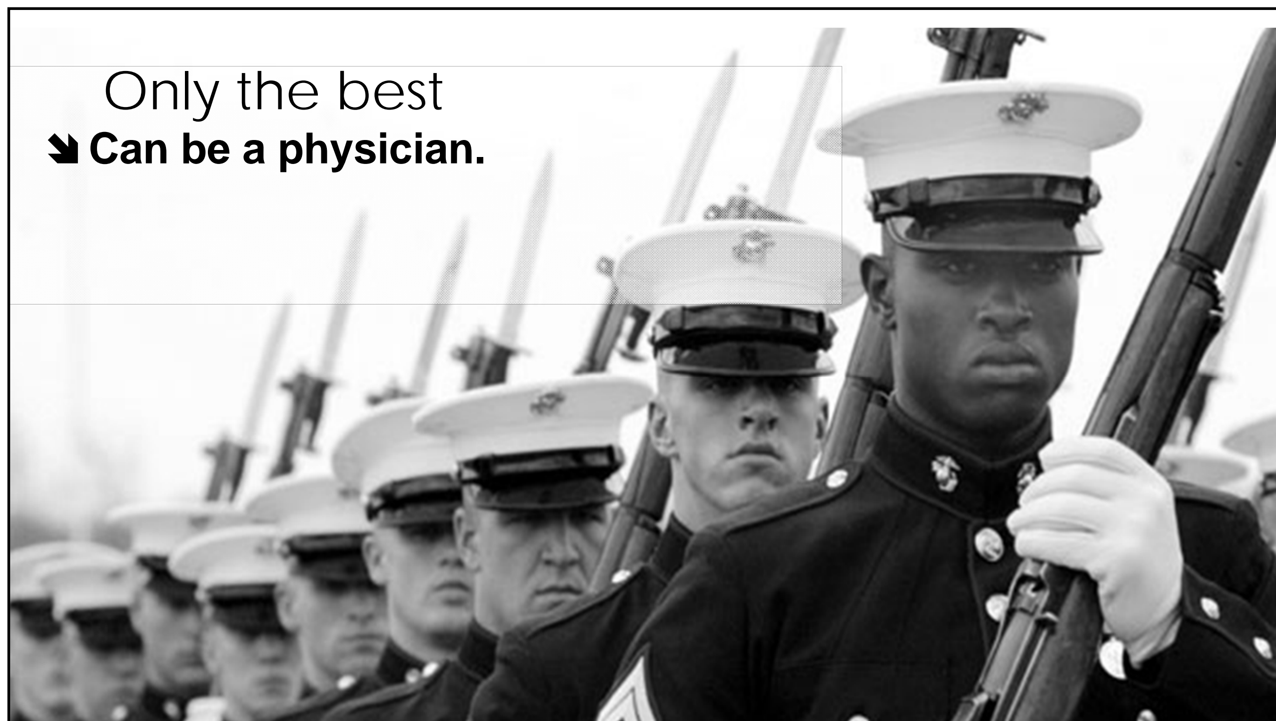
1

Accept That There Is No Tool That Can Replace A Physician In Medical Necessity Determinations on E/M codes.

Five Secrets to Success

2

Understand why the topic of payment is a source of physician frustration Let's take a closer look…



Devaluation of the work by a physician

Payment = (Work RVU x Work GPCI + PE RVU x PE GPCI + MP RVU x MP GPCI) × CF

- 50% of physicians feel devalued
  - RVUs are used in the Physician Fee Schedule
  - The Physician Work RVU is based on government estimates on time and complexity
  - RVUs are used by employers who measure productivity and calculate salaries or bonuses
  - To generate income a physician must be actively providing an allowed service.
    - No payments for work solely humanistic in nature, such as time with a grieving family
    - No payments for time in meeting required documentation requirements
      - Can take 3 or more hours per day

Five Secrets to Success

3

Communicate with physicians quickly, concisely and in terms they can relate to

Inspire me

- Provide a clear vision
  - What makes your heart sing?
- Energy, Energize, Edge, and Execution
  - Dopamine
    - Be memorable
      - Work in emotionally charged moments
      - Teach in a new way, or an unusual place
    - Be novel
      - Fresh, new and unexpected twist
      - Tell a story
      - Tell someone else's story

Scale of 1-5

- Levels 3-5* are reserved for “sick” or injured patients.
  - Lower levels are for patients who present with minor and/or well controlled condition/s.

  - *This presentation refers to levels of service for outpatient visits.

Sickest (5/3)

- Presenting Problem: An illness or injury that poses a threat to life, chronic severely exacerbated, abrupt change in neurological status
  - Typically the patient’s situation is serious, imminent, and uncertain
    - Severe exacerbation of CHF
    - Patient presents confused in diabetic ketoacidosis
    - Morphine Sulfate IVP ordered for chest pain not controlled by Nitro
    - Patient brought by parents after a failed suicide attempt
    - Patient post fall on ski slopes with extradural hematoma
    - hospital inpatient who is rapidly declining

Sick (3/1)

- Typical Presenting Problem: 1 –2 minor, 1-2 stable chronic, 1-2 acute uncomplicated
  - Typically the diagnosis is known and/or made during the encounter
  - Future follow up is often classifiable as routine
    - Patient returns with productive cough x 10 days for antibiotic
    - Patient with choroidal revascularization to assess efficacy of anti-VEGF
    - Follow up Patient with cystocele not requiring treatment
    - Patient in follow up with stable angina and no new symptoms
    - Return visit for patient with worsening plantar fasciitis
    - Non pregnant female with resolving hyperemesis
    - Patient with well controlled hypertension and hypercholesterolemia
    - Hospital patient who is getting better and progressing to discharge

Sicker (4/2)

- Presenting Problem: 2-3 stable chronic, chronic exacerbated, acute with systemic symptoms or injury
  - Typically the diagnosis is known and worsening/complicated or further testing is required
  - Future follow up is often classifiable as routine or sooner
    - Patient with choroidal revascularization now with new central vision loss
    - Patient in follow up with stable angina, not tolerating medication
    - Patient with suspected cellulitis of the lower leg
    - Patient with heel ulcer and drainage
    - Hospital inpatient who isn't getting better or progressing to discharge but is not declining

Five Secrets to Success

4

Master the Art of Asking the Right Questions

CDI: The Physician Interview

- The best way to communicate with physicians is to ask questions that allow them to draw their own conclusions.
  - Your goal is to promote effective communication
  - Ask questions that are not answered with yes or no
  - “what made you more concerned about this patient encounter than the other one?” versus
  - “did you understand what makes this a Level Four?”

Effective Communication

- Listen: Don't think about what you will say next while the physician is talking
- Have a clear idea of what you want to say so you can be organized in your delivery
  - Example:
    - "Doctor, I have reviewed this patient encounter, and your superbill. You selected a Level Four. You saw this patient 1 month ago for premenopausal syndrome mood swings and prescribed Zoloft. You saw her again today in follow-up. You repeated a comprehensive history and exam. She is doing well with reduced mood swings and will continue with sertraline 50MG. You ask to see her back in 12 months or PRN if there is a change. I am concerned that an auditor might question the higher Level of service being billed because you are not seeing her back for 12 months and there are no other problems documented.
    - What was it about this patient that put her at a higher Level of concern to be coded at a Level Four?"

Provider Interview

- Always customize CDI
  - Run a productivity report of the last one to three months of Outpatient visits that shows the top diagnosis codes used and the frequency of their use.
  - Ask Questions: Dr., what about these diagnoses make you more (i.e. 4) or less (i.e. 3) concerned about a patient?

Code	Count of Occurrence	Short Description	Threat to Life/Function	4	3	2	1
D64.9	99	Anemia	Yes/No				
E03.1	96	Congenital hypothyroidism s goiter	Yes/No				
F41.1	76	Generalized anxiety disorder	Yes/No				
I10	42	Essential (primary) hypertension	Yes/No				

Sample Interview Questions

- Do any of these pose a threat to life or bodily function within 24-48 hours? (Level Five)
- Under what circumstances would you see a patient in follow-up sooner than typically required? (Level Four)
- Which patient problems have you very concerned for the patient but do not pose an imminent threat to life or bodily function? (Level Four)
- Which of these can commonly be diagnosed on the first encounter and do not usually require a prompt follow-up? (Level Three)
- Which of these problems might you bring a patient back for a quick check, and on doing so discover no further medical management is needed? (Level Two)
- Which of these diagnoses are self-limited and require reassurance with no active medical management? (Level One)
- Would a non-friendly medical peer agree with your decisions?

Five Secrets to Success

Address the problems head on ---and use effective tools to communicate effectively and code confidently.

Let's address the 2 main problems:

Over-coding Problem

- 99214
- MN is a 3

E& M Code Selection: Quick Reference Sheet
New Out PT 9920(X): Default to the lowest LEVEL identified by the Hx, Ex, & MDM.
Est OT 9921(X): Use the LEVEL identified by the best 2 of 3 on the Hx, Ex, & MDM
(99211 not a Dr Code)

Hx History (3 of 3)

HPI: location, quality, severity, timing, context, mod factor, duration, asso. S&S	ROS: constit, eyes, ENMT, cardio, respir, GI, GU, MS, skin, neuro, psych, endo, hemat/lymph, allerg/immuno	PFSH: past, family, social	Type	New Out Pt LEVEL (x)	Est Pt LEVEL (x)
1	0	0	PF	1	2
1	1	0	EPF	2	3
4	2	1	D	3	4
4	10	3 or2+ (Est.)	C	4 & 5	5

95 Exam
Body Areas: head/face, neck, back, abdomen, genitalia, chest/axillae/breast, each extremity
Systems: constitutional, eyes, ENMT, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin, neurologic, psychiatric, hematologic, lymphatic immunologic

Number of Body Areas/Systems Examined	Type	New Out Pt LEVEL (x)	Est. Out Patient LEVEL (x)
1	PF	1	2
2-7 limited	EPF	2	3
2-7 extended	D	3	4
8 (Systems only)	C	4 & 5	5

MDM Medical Decision Making (2 of 3)

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4/5/2016

HISTORY OF PRESENT ILLNESS: Ms. Smith is a 43-year-old woman with past medical history that includes a pilonidal cyst. This was apparently removed when she was 18. She presents to walk-in today saying that same thing has happened. She has had a couple days of increased swelling in this area. No fevers. Bowel movements are fine.

PHYSICAL EXAMINATION: BP 122/74, pulse 82. She is afebrile. We had a female nurse chaperone in the room during the exam. In the upper aspect of her gluteal cleft there were several scars from her prior surgery. This area was mildly indurated. There was absolutely no erythema but it mildly tender. No drainage.

ASSESSMENT AND PLAN: Dx: Pilonidal sinus. We do not see any active evidence of an infection, but based on the history we will give her a one-week course of Keflex to be sure. She will return to clinic if things do not resolve or if they get worse.

Dr. John Jones

Under-coding Problem

- 99204
- MN is a 5

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Sally M. Smith

4/5/2016

The patient had a sudden central vision loss this morning while working on her computer and was seen at optometrist who sent over to me for retinal diagnosis and treatment. Denies headache and remaining systems are negative. Denies family history of eye problems. Personal history of Lasik for severe myopia. Social history is negative. Both eyes are thoroughly examined. Several optic tests are used, including an Amsler grid and optical coherence tomography which all support sub choroidal neovascularization in the right eye. I recommended a monthly injection of Avastin. I explained the risk of the injections, and shared with the patient the risk of continued vision loss with or without the injection. The patient elected to have the injection today. 1.25 mg in 0.05 ml was injected to right eye. Follow-up in 3 weeks for evaluation and repeat injection.

Dr. John Jones

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The Solution: Communication Improvement

- Fixing the communication problem
  - ✓ Medical Necessity Noted in the Record
    - Coder can prevent over-coding
    - Coder can identify CDI needs to prevent under-coding

Level 1

- I attest that I am billing for what was medically necessary for this patient. The severity of illness and the intensity of service provided by me today is associated with medical needs that were….

- Level 1 Out Pt: For a new Pt with a CC
  - ✓ 1) That required reassurance with no active medical management (or)
  - ✓ 2) Time based: counseling or coordinating care for the patient equal to the Level

Level 2

- I attest that I am billing for what was medically necessary for this patient. The severity of illness and the intensity of service provided by me today is associated with medical needs that were….
- Level 2 Out Pt: For a new or established Pt:
  - ✓ 1) With a minor CC (or)
  - ✓ 2) To follow up to ensure efficacy of previous care

AND

  - ✓ Who required little or no active medical management

OR

  - ✓ Time based: counseling/coordinating care equal to the level

Level 3/1

- I attest that I am billing for what was medically necessary for this patient. The severity of illness and the intensity of service provided by me today is associated with medical needs that were….
- Level 3 Out Pt/Level 1 In Pt.: For a new or established Pt:
  - ✓ 1) With a CC diagnosed during this encounter (or)
  - ✓ 2) To follow up on known problem/s that are progressing as expected

AND

  - ✓ Where the planned return is routine, and/or the problem/s presented no unusual or unexpected concerns for the medical outcome

OR

  - ✓ Time based: counseling/coordinating care equal to the level

Level 4/2

- I attest that I am billing for what was medically necessary for this patient. The severity of illness and the intensity of service provided by me today is associated with medical needs that were….
- Level 4 Out Pt/Level 2 In Pt: For a new or established Pt:
  - ✓ 1) With a CC requiring consideration of multiple comorbidities (or)
  - ✓ 2) With a CC not progressing as expected, (or)
  - ✓ 3) With a CC in a "rule out" stage pending outside tests

AND

- ✓ With medical management requiring consideration of the added risk to the patient's medical outcomes

OR

- ✓ Time based: counseling/coordinating care equal to the level

Level 5/3

- I attest that I am billing for what was medically necessary for this patient. The severity of illness and the intensity of service provided by me today is associated with medical needs that were….
- Level 5 Out Pt/Level 3 In Pt: For a new or established Pt:
  - ✓ 1) With a CC that is a probable threat to life within 24-48 hours (or)
  - ✓ 2) With a CC that is a probable threat to limb within 24-48 hours (or)
  - ✓ 3) With a CC that is a probable threat to organ function within 24-48 hours (or)

AND

- ✓ With medical management requiring consideration of the imminent risk or rapid decline in the patient's medical outcomes

OR

- ✓ Time based: counseling/coordinating care equal to the level

Communication is Key

- To accuracy in medical necessity coding
  - ✓ To preventing overpayments
  - ✓ To minimizing underpayments with clinical documentation improvement training
  - ✓ To reducing the need to query physicians or turn them into coders
  - ✓ To increasing the accuracy and confidence of the coder

Thank you
for your work and for supporting the delivery of excellent healthcare

Stephanie Cecchini, CPC, CEMC, CHISP is LION (Linked In Open Network).
http://www.linkedin.com/in/StephanieCecchini