



ENSURING MEDICAL NECESSITY

THE OVERARCHING CRITERIA

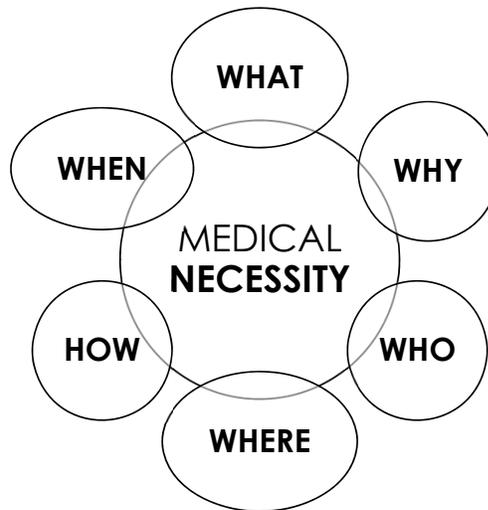
1

The Disclaimer You Knew Was Coming

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2

UNDERSTANDING



3

Overarching Criteria

Center for Medicare Services (CMS) Claims Processing Manual

- ▶ **Medical necessity** of a service 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.
- ▶ The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

4

Medical Necessity Defined

America College of Medical Quality

- **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**.

AMA

- In accordance with the generally accepted standard of medical practice.
- Clinically appropriate in terms of frequency, type, extent, site and duration.
- Not for the intended for the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider.

5

CMS: Reasonable & Necessary Guidelines

- The medical documentation clearly demonstrates that the service meets all of the above criteria.
- All documentation must be maintained in the patient's medical record and be available to the contractor upon request.

The arrival of EHRs and their easy-to-check-off boxes introduced problems associated with cloning.

6

Medical Necessity Criteria

- How often patient was seen for same problem and what was done during those visit?
- How many diagnoses?
- Acuity?
- Duration?
- Severity of problem(s) assessed
- Complexity of documented comorbidities that clearly influenced physician work

7

What duty do Providers owe the Federal health care programs?

Claim Form Language: CMS 1500

Line 31: SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

- **I certify that the statements on the reverse apply to this bill and are made a part thereof.**

➤ NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

➤ NOTICE: I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations

The answer is that all health care providers have a duty to reasonably ensure that the claims submitted to Medicare and other Federal health care programs are true and accurate.

8

The Difference Between “Erroneous” and “Fraudulent” Claims To Federal Health Programs

Fraudulent

- False Claims Act, covers offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim.

Erroneous

- The False Claims Act does not encompass mistakes, errors, or negligence.

9

Clear and Present Danger



10

OIG 2018 Semi-Report to Congress



During FY 2018, OIG reported the following:

- Expected investigative recoveries of \$2.91 billion
- Criminal actions against 764 individuals or entities that engaged in crimes against HHS programs
- Exclusion of 2,712 individuals and entities from Federal healthcare programs
- Civil actions against 813 individuals or entities

11

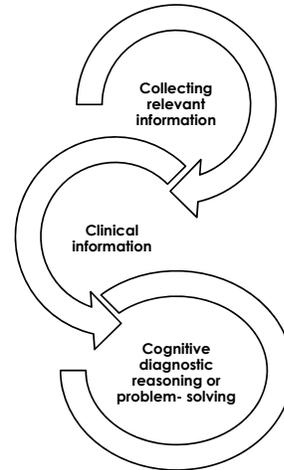
How Different Viewers Interpret Documentation

- How do we decide what to believe?
- The nature of evidence.
 - Dictionary.com, defines "evidence" as "that which tends to prove or disprove something; ground for belief; proof."
- Who really is an authority in this subject?
- Who should we believe?

12

Provider: Patient Care

- ▶ Problem status
 - ▶ Contributing factors
 - ▶ Changes in other systems
 - ▶ Exam findings
 - ▶ Testing needed
 - ▶ Communicating with others
 - ▶ Patient's knowledge level
 - ▶ Severity of the problem(s)
- Clinical Judgment= Level of Service** _____



13

Auditor: Documentation

- ▶ Documentation of History of Present Illness
- ▶ Patient status
- ▶ ROS- pertinent
- ▶ Level of exam appropriate for the nature of the presenting problem
- ▶ Information from others
- ▶ Frequency of service
- ▶ Labs/diagnostic studies
- ▶ Plans
- ▶ Provider of Service
- ▶ Billing Provider

Evidence = Level of Service _____

14

Payer Reimbursement

**Medical Necessity is
all about Payment**

Reimbursement of Service: _____

15

The Pursuit of Clarity

**For evaluation and management
services, the medical necessity criteria
are less clear.**

THE PURSUIT OF CLARITY

16

Evaluation and Management What's in the Documentation?

- The level of an E/M service corresponds to the amount of skill, effort, time, responsibility, and medical knowledge required for the physician to deliver the service to the patient.
- Providers must accurately and thoroughly document that the E/M service was reasonable and necessary.
 - Section 1833(e) of the Act prohibits payment for a claim that is missing necessary information.¹³
- For E/M services, use either the *1995 or 1997 Documentation Guidelines for Evaluation and Management Services* to audit the medical record.

CONTENT OF THE SERVICE

17

FY 19 CMS: Patients Over Paperwork

New or Established

- The chief complaint and other historical information (i.e. **HPI, ROS and PFSH**) can be entered by the ancillary staff or patients.
 - ❖ Practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the patient.
 - ❖ The practitioner may indicate in the medical record that he or she reviewed and verified this information.
 - ❖ Applies to E/M services new and established office visit (99201-99215).

Established

- When relevant information is already contained in the medical record, practitioners would only be required to document what has changed in the history and exam since the last visit or on pertinent items that have not changed.
- Practitioners would not need to re-record these elements (or parts thereof) if there is **evidence** that the practitioner reviewed and updated the previous information.
- Applies to E/M services established office visits (99212-99215).

18

The Art of Auditing E&M History

History of <u>Present</u> Illness (HPI)	Review of Systems (ROS)	Past, Family, Social History (PFSH)
Present Defined: • Existing or Occurring Now	Inquire about system(s) directly related to the problem (s) identified in the HPI plus all additional body systems.	Bringing forward medical history in an EMR.
Chief complaint: • Established the need for the visit	• "All other negative"	Aspect of meaningful use
Sign/symptom/status of problem(s) Diagnosis/Treatment	History intake forms	Do you count that toward the level of the visit?

The extent of the history that is obtained and documented is dependent upon clinical judgement and the nature of the presenting problem.

19

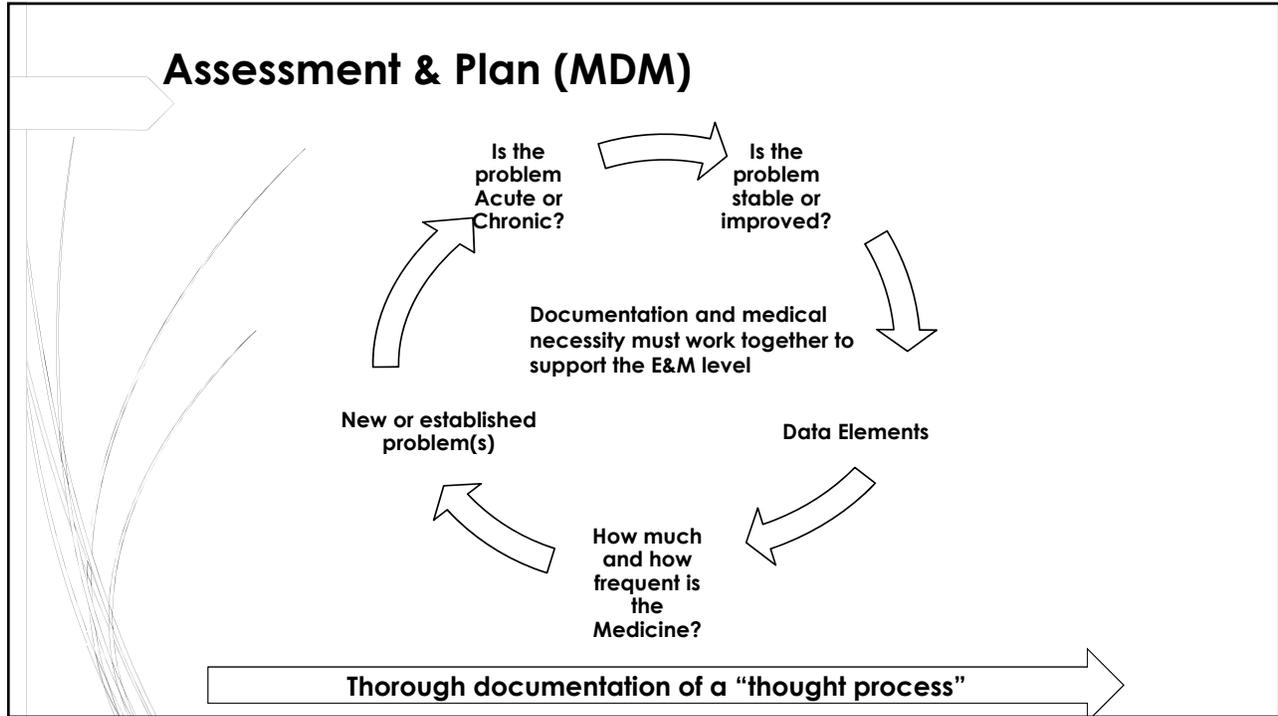
Physical Examination:

Pertinent to the Overall Complexity of the presenting problem(s)

- ▶ Key part of a continuum that extends from the HPI to the therapeutic outcome.
- ▶ Under what circumstances is a comprehensive examination required?
 - It would not be medical necessity to undertake a complete physical examination in most patients presenting with symptoms of an upper respiratory tract infection, or would it?

- Clinical judgment
- Standards of practice

20



21

CPT Clinical Examples

Excerpt from 1992 Federal Register:
 The clinical examples, when used with the revised E/M descriptors and time guidelines provide a new tool for physicians to use to determine the appropriate code for the services provided to their patients.

- 99215:**
 Office visit for 70-year-old female, established patient, with DM, and HTN presenting with a two month history of increasing confusion, agitation and short-term memory loss. (Family Medicine/Internal Medicine)
- 99214:**
 Office visit for a 28-year-old female, established patient, with new onset of low back pain(Pain Medicine)
- 99213:**
 Office visit for a 40-year-old female with well-controlled migraine who desires to remain on the same medication (Neurology)

22

True Grit

Courage and Resolve

23

How EMR can contribute to lack of medical necessity, even with a documented visit

Cut & Paste: Clinical documentation from one visit to another

- The danger here is that unless these items are updated, they neither reflect the patient's status nor do they reflect the actual services provided during the visit.

Templates: Saves time but...accurate documentation?

- May not be worth the extra minutes saved

Free text: Enter all information as free text

- Most systems can't process free text. Thus, the retrieval of data for a variety of purposes is compromised.

All information should add to the utility of the clinical note

24

Frequency and Extent?

Appointment schedule: Follow-up to check blood pressure and response to change in warfarin dosage.

4/26/17: 99215
Copied from 3/28/17

Ventricular tachycardia

- ICD functioning well. Continue carvedilol. No recurrent sustained VT

Ischemic cardiomyopathy

- Denies any angina. Has occluded LAD –single vessel CAD. Continue medical therapy. Follow-up in 6 months.

Paroxysmal atrial fibrillation

- Continue warfarin And metoprolol

Presence of automatic implantable cardioverter-defibrillator

- ICD functioning well. ICD checks as scheduled

Essential (primary) hypertension

- Controlled on medical therapy

TIA (transient ischemic attack)

- Carotid ultrasound bilateral. Continue warfarin. Follow-up with ophthalmologist for transient loss of vision in the right eye

5/27/17: 99215
Copied from 4/26/17

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Documentation Guidelines(DG): The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented

25

The Value of Physical Exam

- Vitals
- Constitutional: Obese female in no apparent distress
- HENT:
 - Head: Normocephalic and atraumatic.
 - Right Ear: External ear normal.
 - Left Ear: External ear normal.
- Nose: Nose normal.
- Mouth/Throat: Oropharynx is clear and moist.
- Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
- Neck: Normal range of motion. Neck supple. No cervical lymphadenopathy present.
- Cardiovascular: Normal rate, regular rhythm, normal heart sounds.
- Pulmonary/Chest: Clear to auscultation bilaterally with no adventitious sounds noted. Unlabored respiratory effort with no use of accessory muscles.
- Abdominal: Abdomen Soft. Bowel sounds present and normoactive. Nontender, nondistended.
- Musculoskeletal: Normal range of motion.
- Neurological: She is alert and oriented to person, place, and time. Patellar and Achilles reflexes 2+ and equal bilaterally.
- Skin: Skin is warm and dry without lesions, rashes or discoloration.
- Extremities: No edema, clubbing, cyanosis, varicosities or tissue breakdown. Distal pulses 2+ and equal bilaterally. Capillary refill <2 seconds bilaterally.
- Psychiatric: She has a normal mood and affect. Her behavior is normal.

**Comprehensive Exam-
Every Patient**

SmartPhrase added by MA at 3/22/2020 8:25 AM

Last refreshed by MD 3/20/2020 11:15 AM

26

Progress Note

- 18 year old presents with 3 day history of headache. No fever, or cough. Tried Advil Allergy and Congestion Relief- mild effect. Seasonal issue. NKDA. Not taking any other méds.
- Exam: Vitals, heart, lungs, eyes, ENT, neck- all normal
- AP: Sinusitis
- Depo-Medrol injection. Return as needed.
- ✓ Low risk to patient



Validate that the medical record contains sufficient documentation to demonstrate that the patient's signs and symptom

Low MDM: Acute uncomplicated illness

- ✓ Overall analysis of the complexity of the entire encounter

27

Define the complexity of the patient at that particular visit: Identified risk factors- chronic problems, multiply medications

Progress Note

- 78 year old presents with 3 day history of headache. Running nose and pressure around eyes. No fever, or cough. Tried Advil Allergy and Congestion Relief- mild effect. Concerned about side effect with **HTN** meds. **DM** running high late afternoon. NO NKDA. Meds. Lantus, lisinopril
- Exam: Vitals, heart, lungs, eyes, ENT, Extremities, lymph, mental status, GI, neck- all normal
- AP: **Sinusitis**- Amoxicillin; **HTN**- stable continue current meds, **DM**, continue current meds. Will order labs to check status. Return in one month or after labs.

99214

Accepted Standards of Medical Practice Badge

- Current knowledge of the patient's clinical status
- Physicians must consider the risk/benefit ratio for prescribing that particular drug for that patient. In addition, physicians must consider the combined risk/benefit ratio when prescribing multiple drugs.

Make sure physicians are documenting any pre-existing medical problems.

28

99215

- 78 year with afib, woke up with palpitations, weakness, lower leg swelling. INR in office 3.9, target is 2.8. Taking Coumadin as prescribed and coming to scheduled Coumadin clinic. No cough, nausea, or nose bleeding. Urine clear. All other systems are negative. DM- doing ok. Some high readings in early morning.
- Exam: Vitals, heart, lungs, eyes, ENT, neck- Lymph, Musculoskeletal, skin, neuro all normal
- AP: worsening afib, increased Coumadin for 3 days. ER warnings, Rt. In 3 days for recheck. DM continue meds, HTN, continue med.

1. What is an INR level of 3.9 means?

- An INR Level of **3.9** is **HIGH** and is higher than your therapeutic INR range of **2-3**. This means your blood is considered "**too thin**"

2. What happens when blood is too thin?

- Greater risk of internal bleeding

3. What are symptoms of Internal Bleeding?

- Falls or accidents, as well as signs or symptoms of bleeding or unusual bruising

High MDM

- ✓ Chronic illness w/severe exacerbation
- ✓ High-risk medication

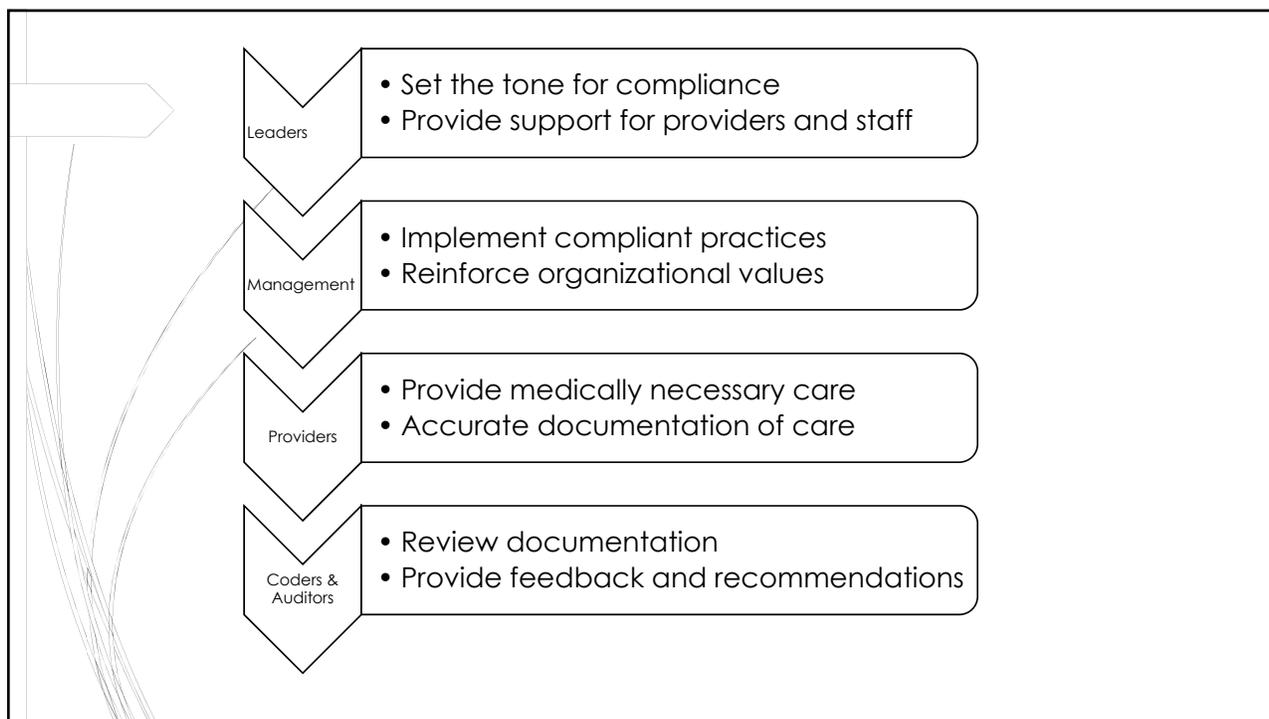
Diagnosis coding helps support medical necessity of the visit.

29

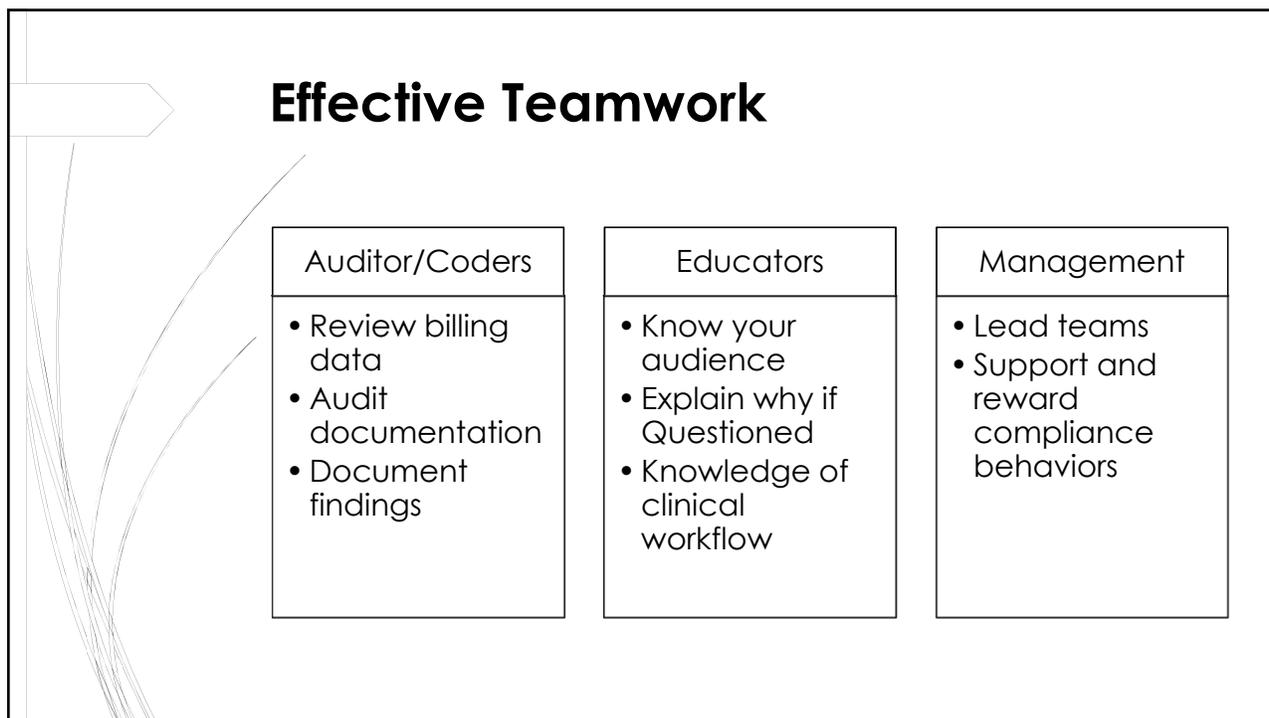


It takes Everyone

30

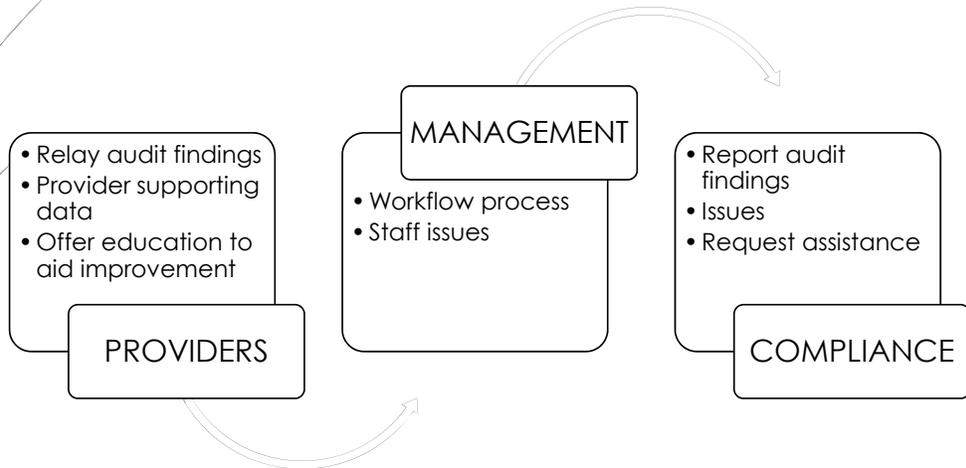


31



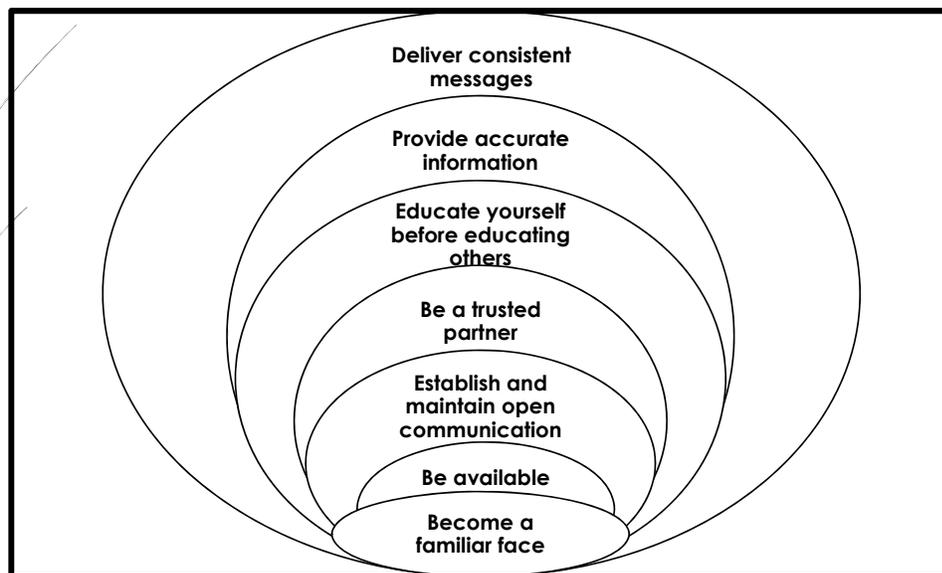
32

Communication



33

A Cycle of Continuous Improvement



34



Know the road ahead

35

CMS CY2020 Proposed Rulings

- CMS propose to establish a general principle to allow the physician, the PA, or the APRN who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team. This principle would apply across the spectrum of all Medicare-covered services paid under the Physician Fee Schedule (PFS).

36

What CMS has to say about documentation using Smart Tools

OIG Report:

CMS AND ITS CONTRACTORS HAVE ADOPTED FEW PROGRAM INTEGRITY PRACTICES TO ADDRESS VULNERABILITIES IN EHRs

January 2014

37

Not all contractors reported being able to determine whether a provider had copied language or over-documented in a medical record

CMS stated that the use of audit logs may not be appropriate in every circumstance and that review of audit logs requires special training.

Contractor	Copied Language EHR	Overdocumentation
MAC	4 out of 8	1 out of 8
RAC	3 out of 4	1 out of 4
ZPIC	2 out of 6	1 out of 6

38

Number of Contractors That Reported Receiving Guidance From CMS Related to EHRs

CMS stated that intends to develop guidance on the appropriate use of the copy-paste feature in EHRs.

CMS Guidance	MAC	RAC	ZPIC
Copied language	0 out of 8	2 out of 4	0 out of 6
Overdocumentation	1 out of 8	1 out of 4	0 out of 6
Electronic Signatures	6 out of 8	3 out of 4	0 out of 6
Other EHR-related guidance	2 out of 8	1 out of 4	0 out of 6

39

THANK YOU!

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40