Medical Necessity of the E&M Encounter

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NAMAS Conference

- December 5-8\textsuperscript{th}, 2017
- Loews Sapphire Falls at Universal Orlando
- Compliance Track
- Physician Auditing Track
- Facility Auditing Track
- FQHC Auditing Track (Pre-Conference Event)

Medical Necessity

Coder Education vs. Auditor Education
- Coders are taught to look for documentation content only
- Most training programs for coders do not teach medical necessity, and therefore most coders have a hard time with medical necessity

Clinician vs. non-clinician review
- Know the non-clinical role and don’t cross it
- Evaluate documentation of the medical necessity only

Complexity of Care
- A better term to explain what medical necessity truly is
- How complex was the patient encounter?
- Terminology helps to avoid confusion with medical decision making
- Painting a portrait of the patient
Medical Necessity

Fundamentals

- **Social Security Act**: Section 1862 (a)(1)(A) states: "No payment will be made ... for items or services ... not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member."

- **Medicare Claims Processing Manual**: Publication 100-04, Chapter 12, Section 30.6.1 states: "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."

- **What do the MACs say?**
  - Most have no additional information on medical necessity

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**Medicare Claims Processing Manual**

Chapter 12 - Physicians/Nonphysician Practitioners

May 26, 2003

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30.6.1 - Selection of Level of Evaluation and Management Service

(Rev.)

Physicians must select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for noninpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection A below.

The physician must have provided all the services necessary to meet the CPT description of the level of service billed. A claim for a service must reflect the service actually performed. A physician may submit a claim for CPT code 99499, "Unlisted evaluation and management service", with a detailed report stating why the visit was medically necessary and describing what service(s) was performed. The carrier has the discretion in valuing the service when the service does not meet the terms of the CPT description (e.g., only a history is performed). CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

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**Medicare Claims Processing Manual**

Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 3476, 05-11-16)

30.6.1 - Selection of Level of Evaluation and Management Service

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

A. Use of CPT Codes

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS), and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

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.
Medical Necessity

Carrier Opinion

- Since CMS has no “measuring stick” on how to score medical necessity – we are left with “opinion” and “interpretations” in the healthcare industry on how to score medical necessity.
- Two common Misinterpretations:
  - **Misinterpretation #1**: Use the chief complaint to define the medical necessity of the encounter.
  - **Misinterpretation #2**: The level supported by the MDM is the level of service that should be assigned through medical necessity.
    - MDM is only one portion of the entire encounter, and if we only evaluate it in the documentation, we are not giving fair representation of all of the work of the provider through the “interview” of the patient and the exam and workup of the patient.
Medical Necessity

Medical Necessity Opinions

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**Medical Necessity**

Consider the following 2 scenarios and their adverse affects on using MDM only

**Evaluation of a patient with a single chronic, stable comorbidity (such as DM) presents to the clinic for a 6 month follow up and medication refill.**

Scoring the MDM only for such encounter would note:

• Number of diagnosis and points assigned: 1 point established stable problem
• Data and complexity reviewed: 1 point (at most) for review/order labs
• Table of risk: Moderate for prescription management
• MDM level of service: 99212

• Is managing a patient with diabetes seriously represented of only a level 2 encounter?
• The provider must continually evaluate the patient’s liver, kidneys, and cardiovascular system, along with managing their DM. This is not a minimal presentation problem

**A new patient presents to an urgent care with presentation of sinus pain/pressure and upon evaluation the patient is diagnosed with sinusitis and given a Z-pack.**

Scoring the MDM the encounter would be:

• Number of diagnosis and points assigned: 3 points new problem w/o + work up
• Data and complexity reviewed: 0 points-nothing ordered/reviewed
• Table of risk: Moderate for prescription management
• MDM level of service: 99204

• Is sinusitis REALLY a level 4?
• Are we really indicating that a sinus infection is higher complexity of care then diabetes?
Medical Necessity

NAMAS Methodology

- CMS indicates that the patient's presenting problem should drive the medical necessity of the encounter.
- There is one place in 1995 and 1997 Documentation Guidelines that a patient’s presenting problem is equated to level of service – The Table of Risk.
- NAMAS scoring recommends that we equate the complexity of care as documented to the levels to assess the medical necessity for assigning the level of service.

### TABLE OF RISK

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One minor problem, insect bite, tinea corporis</td>
<td>Laboratory tests requiring venipuncture, Chest x-rays, EKG/EEG, Urinalysis, Ultrasound, eg, echocardiography, KOH prep</td>
<td>Rest, Gargles, Elastic bandages, Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems, One stable chronic illness, eg well controlled hypertension or non-insulin dependent diabetes, cataract, BPH, Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain</td>
<td>Physiologic tests not under stress, eg, pulmonary function tests, Non-cardiovascular imaging studies with contrast, eg, barium enema, Superficial needle biopsies, Clinical laboratory tests requiring arterial puncture, Skin biopsies</td>
<td>Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy, Occupational therapy, IV fluids without additives</td>
</tr>
</tbody>
</table>

Continued...
**Medical Necessity**

*WARNING*

- Scoring the medical necessity is a separate function from auditing the note for documentation content.
- Approach
  - Bottom’s Up Auditing: Assessing the medical necessity of the encounter first and then ensuring the documentation also meets the same level
  - Evaluation Process: Audit the encounter for documentation ONLY, and once you determine the level of service, then assess the level of medical necessity.

**Acute Problems: Office Setting**

New or Established Patients

- **Level 5**
  - The acute problem poses threat to life or bodily function during today’s encounter
- **Level 2**
  - The problem is minimal in nature and questionable if the patient even truly needed to be seen on that given date of service
- **Level 4**
  - The problem is acute with complicating factors contributing to the complexity of caring for the patient on this date of service
- **Level 3**
  - The problem is acute and uncomplicated in presentation to the provider
Chronic Problems: Office Setting

New or Established Patients

LEVEL 5
The chronic problem is severely exacerbated and posing threat to the patient

LEVEL 3
The problem is a chronic stable problem and currently not exacerbated

LEVEL 4
A chronic problem that is exacerbated or the management of 2 chronic problems

LEVEL 2
The problem is minimal in nature and questionable if the patient even truly needed to be seen on that given date of service

Inpatient Encounters:
Initial or Subsequent

Level 3: High severity that would require significant "tweaking" to reach a more stable state

Level 2: Moderate severity that still requires "tweaking" but the patient is beginning to reach a more stable state

Level 1: Low severity which would indicate that the patient has reach a stable state
Emergency Department

Medical Necessity

Scoring Technique
- We will be using these medical necessity charts to apply to the plan of care (MDM) as well as the history.
- History should identify the severity of the patient according to the patient.
  - Chief complaint – Presenting Problem
  - HPI – Symptoms caused by the chief complaint
  - ROS – how the patient’s body is being affected by the chief complaint
  - PFSH – how the patient’s history may impact treating their presenting problem or vice versa
- Step #1: Compare your medical necessity chart to the overall severity of the patient according to the patient as noted in their history.
Medical Necessity

• Step #2: The plan of care (MDM) should document the severity of the patient according to the provider’s clinical analysis of the patient.
  • Number of diagnoses: will define how complex the problem(s) are and if multiple problems were adequately addressed, the complexity of treating a patient with multiple issues.
  • Data and complexity of what was reviewed or ordered tells a story of the provider’s work to determine the clinical interpretation of the patient’s severity.
  • The Table of Risk equates the highest level of risk involved with treating the patient.
  • Consider the exam – do the findings support the same level?

Medical Necessity

• Step #3: Compare the history severity to the plan of care severity to determine an overall complexity of care.
  • If the documentation supports a higher level of service than the medical necessity, then we must default to the lower level of service.
  • If the medical necessity supports a higher level of service than the documentation, then the lower level of the documentation must be used.
  • Essentially, the lower level of service defines the overall level of service.
Jackson presented to the office with a cough, sore throat, but no fever. The symptoms have been present for 3 days but are not getting any worse.

Dr. Adams advises the problem is sinusitis, prescribes a Z-Pack, and recommends OTC Zyrtec nose spray.

According to Jackson, what is the severity of his problem?

Jackson indicates that his problem is acute in presentation, but offers nothing to indicate that it is complicated at this time.

According to Dr. Adams, what is the documented clinical severity of the problem?

Dr. Adams gives Jackson a “treatment” that requires no additional testing, procedures, or referrals – also indicating his problem is acute and uncomplicated.

What is the overall level of service supported by the complexity of care (i.e., the medical necessity?)

Level 3, because referring to the acute bubble chart, an acute uncomplicated problem is a Level 3.

**Equating the Medical Necessity**

Medical necessity reviews MUST be a part of every audit in order for the review to be effective, and there must also be balance between the documentation content and the medical necessity.

While medical necessity is the overarching defining factor of the level of service, the documentation guidelines must also be met for that level of service in order for the code to be fully supported.

Meaning, if the documentation supports a 99215, but the medical necessity of the encounter can only support a 99213 then we must default to the lower level of service.

As well, vice versa- if the documentation was only a 99213, but the medical necessity is a 99215 we would have to report the lower level of service in this scenario as well.
REMEMBER!!

- Documentation and medical necessity MUST work together.
- The lowest of the two defines the level of service.
- If you are not a clinician - do NOT try to abstract clinical necessity.
- Base ALL interpretations on the way in which the provider painted the portrait of the patient through their documentation.

Auditing Policy Alert

- Your organization must have a clearly defined method of extrapolating Medical Necessity. This will ensure all auditors are evaluating records in the same manner.
- Consider:
  - MDM vs. Extrapolation technique for determining the medical necessity.
  - Identify that all first level reviews are done by non-clinicians, but escalation to peer-to-peer is available at define at what frequency or interval.
New patient who presents with complaints of bloody stools from his rectum and he states this problem has been present for approximately 2 days. The emesis is noted occasionally and not with every bowel movement and he does have complaints of nausea but no vomiting. He has felt weak and clammy, no visual disturbances, and no lightheaded concerns.

Review of Systems: Other than as noted in the HPI, all other systems are negative as they pertain to the patient's chief complaint.

PMH: Abnormal liver functions per patient approximately 1 year ago

FMH: There is a family history of alcoholism and cirrhosis of the liver

SH: The patient has been tobacco free for the past 5 years but previously smoked for 20 years' prior approximately 1 pack every 2 days. He states his alcohol use is in moderation with only limited consumption during the week

Exam:
Constitutional: Patient is pale in presentation and looks sickly
Eyes: Blood shot and yellow
Cardiovascular: Edema in the lower extremities
Respiratory: Lungs sound wet and respirations are minimally labored
GI: Abdomen is distended by ascites with positive fluid waves. Positive HSM
Skin: Jaundice
Neurologic: Alert and oriented and appears to not have any positive concerns
Psych: Behavior is guarded and agitated

Assessment and Plan:
Emesis- evaluation for possible internal bleed
Alcoholic Prior to today's encounter, the patient's wife contacted me to notify me that the patient would "down-play" his alcohol use. She indicates that he is currently consuming a 5th of Jack Daniels, Vodka, and at least a 12 pack each week. He blames his drinking on working night shift.

I spoke about these concerns to the patient and he tries to deny the volume of alcohol, but finally breaks and admits to overconsumption, overuse, and a blatant abuse of alcohol. Based on the patient's previous history of abnormal liver functions, family history all complicating his current condition, there is significant concern that this patient may have a GI bleed and has progressed toward liver compromise. I have called and spoke with Dr. Womack over at GI Comprehensive Care Group and he has requested that we send the patient to the emergency room ASAP, and he will meet him there.

Of concern is the patient's resistance to recognize the potential liabilities of his current state of health and the effects of continued alcohol use per his family. I have encouraged that if he is not interested in AA meetings, that there are other support groups and individual counseling that we could help him obtain. Inpatient rehab may be a better alternative answer for someone in his condition.

Electronically signed by Finn Turner, M.D.

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Mr. Kennedy presents to the clinic today as a new patient with complaints of urinary frequency. He states that as any aging man, he notes that he has had an increase in frequency during the night, but for the past 2 weeks the frequency has increased. At times, he is voiding twice an hour. He notes pain and burning on urination, but states that is not the case with every event. His wife suggested cranberry juice and yogurt to try and help, but they have not offered any change.

Review of Systems: No fever, no noted weight loss or weight gain, and no abdominal pain.

Exam:
Well-nourished and well appearing gentleman. His mood is a bit agitated.
He is engaged and focused in the conversation being alert and oriented with good mood and affect
Abdomen: Soft and non-tender with no palpable GI pain

Labs: UA performed with relatively normal findings

Diagnosis: Urinary frequency
Plan: It does not appear that Mr. Kennedy has a UTI at this point based on the assessment. I have ordered a PSA and other labs per written order in this record. We will wait on the labs to see if he would benefit from a full work by a specialist. We will call him with the results when they come in and at that time we will discuss if a referral to a specialist is indicated.

This record is electronically signed by Al Roata, MD
Date of encounter: January 21, 2017
Patient Name: Sonia Drake
Date of Birth: 8-16-1996

Chief Complaint: Acne
New Patient: The patient is female who presents today as a new patient with her mother for evaluation and options for treatment of acne. The acne is diffuse across the patient’s face, chest, and back and she has tried over the counter remedies including Proactive. With these she has seen minimal changes, but nothing long lasting. She first noted significant issues with acne when she was 12-year-old. The acne is itchy and bothersome causing her to pick at it but no other skin lesions/rashes. She has no complaints of any weight loss/gain recently.

Exam:
Constitutional: WNWD during encounter
Skin: Facial skin shows a diffuse profusion of comedopapular acne which extends down the neck across the chest to approximately the nipple line, and down the back. Some areas show early scarring, and she does not some pain with palpation of the acne during the exam

Diagnosis: Comedopapular Acne
UA Pregnancy test performed and negative

Patient expresses sincere desire for effective treatment of acne. Due to the extent of the patient’s acne and the resistance to other medications, I will accommodate her with beginning acne management using Accutane.

The patient is reportedly NOT sexually active at this time, but given the risks of complication that Accutane represents, not only will I prescribe the Accutane, but I will also require that she be placed on contraception. We will prescribe her a 30-day supply of Accutane, with the understanding that if she presents without active birth control script at her next visit, we will discontinue the treatment.

Electronically signed by Jessica Baldwin, PA-C

For More Information
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