

CRASH COURSE MEDICAL NECESSITY SKILLS FOR NON PROVIDERS



PRESENTED BY:

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About the Presenters

Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE: Ms. Mac has served the health care industry for over 20 years. Currently, Maggie is a Senior Coding Manager for Aviacode in Salt Lake City, Utah, overseeing the coding team for Temple University Hospital. She is also the Director of Network Compliance with Mount Sinai Medical Center - Compliance Department in New York City. Maggie is a frequent contributor to and serves on the Editorial and Consulting Advisory Board to many health management and coding publications. She has earned numerous awards for her contributions to the healthcare community across the country.

CODER

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Stephanie L. Jones Cecchini, CPC, CEMC, CHISP, Approved ICD-10 Trainer: Stephanie is VP of Coding Operations for Parses, Inc, its sister company. As Chief Audit Officer for Parses, Inc, she assured physician audit accuracy & driving sales & managing new audit programs. Stephanie is an executive level health care operations manager for multi-specialty physician groups, hospitals, and payers. She has extensive experience in using data to identify coding errors and recoup overpayments for both federal and commercial payers.

TEACHER

SIDEKICK

Stephanie is LION (Linked In Open Network). <http://www.linkedin.com/in/StephanieCecchini>

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Objectives

1. Three little known secrets to accurate E/M coding
2. The definitions of Medical Necessity for purposes of accurate coding
3. How to clinically differentiate E/M service Levels
4. Effective techniques for communication with physicians regarding Medical Necessity
5. How to have confidence in selecting the correct E/M level

Effective Documentation?

- Clinically relevant
- Easy to navigate
- Provides a record of the patient problem and their care
- Allows for continuity of care
- Provides a billable record of care
 - Medical Necessity
 - Documentation Guidelines



The Medical Necessity Problem

- Medicare fee-for-service improper payments increased 18% to \$36B in 2013
 - The primary cause is insufficient documentation(63%).
 - The other cause is classified as Medical Necessity errors (37%)
- CMS 1995 and 1997 Documentation *Guidelines* are not statutes
 - Medical need for services rendered is the authoritative factor
- Medicare may deny payment for a service that the physician believes is clinically appropriate, but which is not reasonable and necessary



Coder Silence is Damaging

- EHRs are producing more “false positives” to higher levels of service
- Unvoiced concerns lead to over-payments and negative payer audits
 - Audits projected to rise in 2014
 - 2013 CMS reported an error rate of 10.1% for FFS.
 - This is an increase from 9.9% in 2012.
 - This exceeds Improper Payments Elimination and Recovery Act of 2010 (IPERA)

What is Medical Necessity?

- 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

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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."

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“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.

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Leaves a Coder with Two Questions

1. How sick does a patient have to be in order to fall into one of the 5 Levels of care (Outpatient) or 3 Levels of care (Inpatient);
 - **How sick is sick?**
2. Who can authoritatively say how sick a patient is;
 - **Who can say how sick is sick?**

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CPT Nature of the Presenting Problem

How sick is sick?

1. 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.
2. 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.
3. 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.
4. 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.
5. 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?

How sick is sick?

Example of a Level 4 MDM: New Problem tx c Rx

MDM Medical Decision Making (2 of 3)		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
NUMBER OF DX and MANAGEMENT OPTIONS	AMOUNT/COMPLEXITY OF DATA: One Point Each: • 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 Two Points Each: • Review/summarize data old records/add hx other than pt • Independent interpretation of an image, tracing, specimen			
1	1	Clinical testing/management examples: Venipuncture, X-ray, EKG, U/A, U/S, rest, superficial dressings, elastic bandage, gargles, etc. Presenting Problem Example: 1 minor / self-limited	SF	1 & 2
2	2	Clinical testing/management examples: Biopsy, pulmonary function, barium enema, minor surgery without risk factors, OTC drugs, PT, OT, IV without additives, etc. Presenting Problem Example: 1-2 minor, 1 stable chronic / 1 acute uncomplicated	L	3
3	3	Clinical testing/management examples: Stress tests, endoscopies, cardiovascular imaging, corticoids, closed Tx of fx, Rx drug management, minor surgery with risk factors, major elective surgery without risk factors, therapeutic radiation tx, etc. Presenting Problem Example: 1 chronic exacerbated / 2 stable chronic / New Undiagnosed with uncertain outcome / Acute with systemic symptoms / acute complicated injury	M	4
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

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.*

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Answer is a Level Four, right? Well...

- What if....
 - Patient was sent same day to be worked up at an outside facility
 - Provider decides that the risk is high?
 - This is a 5
- Another example :
 - *45 year old, otherwise healthy male returns for a non-resolved problem first seen 5 days agoa 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?

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How
sick is
sick?

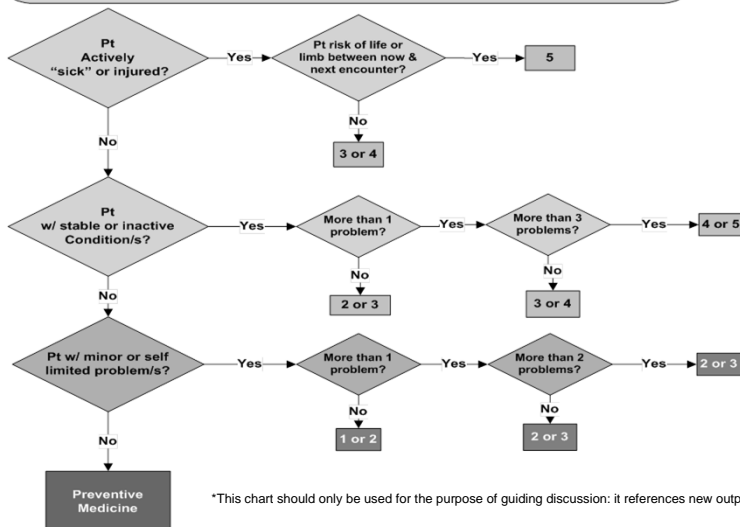
Who Can Say How Sick is Sick?

Who can say?

- Nature of the presenting problem --- still vague
- MDM as a driver --- still not “a silver bullet
- What’s left?
 - The physician
 - **Superpower# 1**
 - **Medical Necessity criteria is best explained in laymen’s terms that allows the physician to define the detail using their own advanced knowledge.**

Start:
A medically necessary, separately billable, evaluation and management service.
Dr. is treating (or Tx is impacted by all diagnoses counted)

How sick is sick?



*This chart should only be used for the purpose of guiding discussion; it references new outpatient visits

Scale of 1-5

How
sick is
sick?

- 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.

Hospital Patients

How
sick is
sick?

- How sick is sick?
 - Scale of 1-3
 - Level One hospital visit is for a patient who is getting better
 - Level Two hospital visit is for a patient who isn't getting better
 - Level Three for a patient who is rapidly declining.

Sickest (5/3)

How
sick is
sick?

- 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

Sick (3/1)

How
sick is
sick?

- 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

Sicker (4/2)

How
sick is
sick?

- 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

CDI and Educating the Physician

• Superpower #2

- **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?”

Sample Questions

- Tell me about your worst patient case---how did the patient present?
Was the patient at risk for lost life or bodily function?
- Would a non-friendly peer agree that the patient was “sicker” ---albeit not at imminent risk for lost life or bodily function?
- Is it reasonable that this “sicker” patient needs to be seen in follow-up shortly?
- What lesser but related problem would have you less concerned?

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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?”

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Watch Your Body Language

- Body language mistakes to avoid are:
 - Arms crossed: You are defensive.
 - Constant eye contact: You are aggressive.
 - Fidgeting: You are bored or impatient
 - Hunched Posture: You lack confidence.
 - Little eye contact: You have low interest or lack confidence.
 - Rubbing your nose or mouth: You are lying or unsure of yourself.
 - Tapping: You are impatient or nervous.
 - Touching your face or hair: You are timid.
 - Watching the time: You are anxious to move on to something else.

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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
702.0	99	ACTINIC KERATOSIS	Yes/No				
239.2	96	BONE/SKIN NEOPLASM NOS	Yes/No				
706.1	76	ACNE NEC	Yes/No				
706.8	56	SEBACEOUS GLAND DIS NEC	Yes/No				
216.3	47	BENIGN NEO SKIN FACE NEC	Yes/No				
702.19	45	OTHER SBORHEIC KERATOSIS	Yes/No				
228.01	42	HEMANGIOMA SKIN	Yes/No				

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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?

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Mastering a Good Coder-Physician Relationship

- **Superpower #3**
 - Coders, unlike any other position in healthcare, are capable of helping physicians.

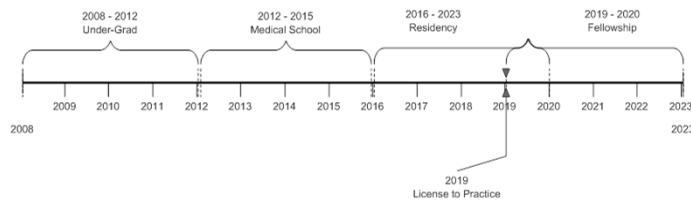
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Sir Luke Fildes's 1891 painting 'The Doctor.'



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Appreciating Physician Development



- 80% of those in pre-med will not be accepted to medical school
- Medical school
 - Average student financial debt in 2012 was \$166K
 - The majority of students will graduate with debt of at least \$150,000

Growing Numbers Need Help

- 700K physicians in the US
 - 63% (442K) bill E&M services
 - 20% (and growing) are employed by hospitals
- 63K fewer doctors than needed by 2015
- 33% are in Private practice ↓ From 57% in 2007
- 46% would NOT choose medicine again as a career
- On again, off again regulations (SRG, ICD-10),
- Difficult rules (E/M, HIPAA, MU), high costs (malpractice)

The Solution



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Questions?

"Medicine is the only profession that labours incessantly to destroy the reason for its own existence." ~James Bryce, 1914

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