Objectives

We will first look at Medical Decision Making in detail.
We will then look at Medicare’s definition of Medical Necessity
We will discuss the differences
We will discuss what appears to be the easiest way for a coder to understand and decide medical necessity.
Medical Decision Making

Audit Tools
Marshfield Clinics
The old Trailblazers tool
Hybrids

For the most part we all can agree that most of the tools are very similar with the exception of the trailblazers tool.
**Quick-Reference Code Sheet**

**New PT and Consult:** Default to the lowest LEVEL identified by the Hx, Ex, & MDM

**Est PT:** Use the LEVEL identified by the best 2 of 3 on the Hx, Ex, & MDM (99211 not a Dr Code)

<table>
<thead>
<tr>
<th>HPI: location quality severity timing</th>
<th>context mod factor duration asa S&amp;S</th>
<th>ROS: constit eyes ENMT GI GU cardi resp skin</th>
<th>PFISH: past family social</th>
<th>Hx History (3 of 3)</th>
<th>New Out Pt or Consult Pt LEVEL</th>
<th>Est Out Pt LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>PF</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>EPF</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 or 1997:3 chronic</td>
<td>2</td>
<td>1</td>
<td>D</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4 or 1997:3 chronic</td>
<td>10</td>
<td>3</td>
<td>C</td>
<td>4 &amp; 5</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**Ex 95 DG Exam**

<table>
<thead>
<tr>
<th>Body Areas:</th>
<th>Systems:</th>
</tr>
</thead>
<tbody>
<tr>
<td>head/face</td>
<td>musculoskeletal</td>
</tr>
<tr>
<td>neck</td>
<td>skin</td>
</tr>
<tr>
<td>back</td>
<td>neurologic</td>
</tr>
<tr>
<td>abdomen</td>
<td>psychiatric</td>
</tr>
<tr>
<td>genitalia</td>
<td>respiratory</td>
</tr>
<tr>
<td>chest/axilla/breast</td>
<td>gastrointestinal</td>
</tr>
<tr>
<td>each extremity</td>
<td>genitourinary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Body Areas/Systems Examined</th>
<th>Type</th>
<th>New Out Pt or Consult Patient LEVEL</th>
<th>Est Out Patient LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PF</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2 Limited</td>
<td>EPF</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2 Extended</td>
<td>D</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8 (Systems Only)</td>
<td>C</td>
<td>4 &amp; 5</td>
<td>5</td>
</tr>
</tbody>
</table>

**MDM Medical Decision Making**

**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:**

- 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

**OVERALL RISK:**
The quick reference guide below shows excerpts from the CMS Table of Risk.

*Remember: Risk is based on the disease process anticipated between the present encounter and the next one.

<table>
<thead>
<tr>
<th>Presenting Problem Example</th>
<th>Type</th>
<th>New or Est Out Pt or Consult LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 minor / self limited</td>
<td>SF</td>
<td>1 &amp; 2</td>
</tr>
<tr>
<td>Biopsy, pulmonary function, barium enema, minor surgery without risk factors, OTC drugs, PT, OT, IV without additives, etc.</td>
<td>L</td>
<td>3</td>
</tr>
<tr>
<td>1–2 minor, 1 stable chronic / 1 acute uncomplicated</td>
<td>M</td>
<td>4</td>
</tr>
<tr>
<td>Stress tests, endoscopies, cardiovascular imaging, cervices, closed Tx of fx, Tx drug management, minor surgery with risk factors, major elective surgery without risk factors, therapeutic radiation tx, etc.</td>
<td>H</td>
<td>5</td>
</tr>
</tbody>
</table>

**Clinical testing/management examples:** Venipuncture, X-ray, EKG, U/A, U/S, rest, superficial dressings, elastic bandage, gurgles, etc.

**Presenting Problem Example:** 1 chronic exacerbated / 2 stable chronic / New Undiagnosed with uncertain outcome / Acute with systemic symptoms / acute complicated injury

**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
Components of MDM

- Diagnostic Options
- Data
- Table of Risk
# Diagnostic Options

<table>
<thead>
<tr>
<th>Option</th>
<th>Points</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Est. Problem, stable – Improve (to examiner)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Est. Problem, worsening (to examiner)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>New Problem, no additional workup planned (to examiner)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>New Problem, additional workup planned (to examiner)</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
How do we as coders decide when a problem is self limiting or minor, verses and established problem, stable improved ??????
Diagnostic Options

What makes a presenting problem, worsening?
Does the provider have to state the problem is worsening?
Can we as coders make decision based on lab, xray, etc.?
Diagnostic Options

- What constitutes a work up?
- When does it have to be done?
## Amount and/or Complexity of Data

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order clinical lab tests of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order radiology tests of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order tests from the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Discussion to obtain old records and/or obtaining history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review an summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total**
# Table of Risk

<table>
<thead>
<tr>
<th>Presenting Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal:</strong> One self limited or minor problem (eg: cold, insect bite, tinea corporis)</td>
</tr>
</tbody>
</table>
| **Low:** Two or more self-limited or minor problems,  
One stable chronic illness (eg: Well controlled hypertension, non-insulin dependent diabetes, cataract, BPH)  
Acute uncomplicated illness or injury (eg: Cystitis, Allergic Rhinitis, simple strain) |
| **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 (lump on Breast)  
Acute Illness with systemic symptoms (Pyelonephritis, pneumonitis, colitis)  
Acute complicated injury (eg: head injury with brief loss of consciousness) |
| **High:** One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
Acute or chronic illnesses or injury that pose a threat to life or bodily function (eg: multiple trauma, acute MI, pulmonary embolism, severe respiratory distress progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure)  
An abrupt change in neurologic status (e: seizure, TIA, weakness, sensory loss) |
## Table of Risk

<table>
<thead>
<tr>
<th>Diagnostic procedure(s) Ordered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal:</strong> Laboratory tests requiring venipuncture, Chest Xrays, EEG/EKG Urinalysis, Ultrasound, Echo, KOH Prep.</td>
</tr>
<tr>
<td><strong>Low:</strong> Physiologic tests not under stress, eg: pulmonary function test, non-cardiovascular Imaging studies with contrast eg: barium enema, superficial needle biopsy, clinical laboratory tests requiring arterial puncture, skin biopsy</td>
</tr>
<tr>
<td><strong>Moderate:</strong> Physiologic tests under stress eg: cardiac stress test, fetal contraction stress test, diagnostic endoscopies with NO identified risk factors, deep needle or incisional biopsy, cardiovascular imaging studies with contrast and no identified risk factors, arteriogram, cardiac catheterization, obtain fluid from a body cavity, eg: lumbar puncture, thoracentesis</td>
</tr>
<tr>
<td><strong>High:</strong> Cardiovascular imaging studies with contrast with identified risk factors, cardiac electrophysiological tests, diagnostic endoscopies with identified risk factors, discography</td>
</tr>
</tbody>
</table>
## Table of Risk

<table>
<thead>
<tr>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal: Rest, Gargle, elastic bandages, superficial dressings</td>
</tr>
<tr>
<td>Low: Over the counter drugs, Minor surgery with no identified risk factors, Physical Therapy, occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td>Moderate: minor surgery with identified risk factors, Elective major surgery with no identified risk factors, Prescription drug management, Therapeutic nuclear medicine, IV fluids with additives, closed treatment of fractures or dislocation without manipulation</td>
</tr>
<tr>
<td>High: Elective major surgery, emergency major surgery, parenteral controlled substances, Drug therapy requiring intensive monitoring for toxicity, decision not to resuscitate or to de-escalate care because of poor prognosis.</td>
</tr>
</tbody>
</table>
Final Results for Complexity
Only need 2 out of three

<table>
<thead>
<tr>
<th></th>
<th>Number of diagnosis or treatment options</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Amount and complexity of data</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>C</td>
<td>Risk of complications</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Type of Decision Making</td>
<td>Straight-forward</td>
<td>Low Complex</td>
<td>Moderate Complex</td>
<td>High Complex</td>
</tr>
</tbody>
</table>
Where do we go from here

When determining the level of service the guidelines tell us that for new patients we need all 3 components History, Exam and Medical Decision Making.

They also tell us that for establish patients we only need 2 of 3 components.

They don’t tell us which 2 components we have to use. (Is this a problem?)
Medical Necessity

• Who should determine this?
• Why?
• What can we do as coders to assist with this?

Discussion
Medical Necessity

• What does CMS have to say?

“No payment may be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”
• Have you or your provider ever read the back of a CMS 1500.

“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.”

“ I certify that the services shown on this form were medically indicated and necessary for the health of the patient”
Evaluation and Management

• Medical necessity of an E&M service is generally expressed in two ways: Frequency of services and intensity of service (CPT level).

• Medicare’s determination of medical necessity is separate from its determination that the E&M service was rendered and billed.
Medicare say they determines medical necessity largely through the experience and judgement of the clinician, coders along with the limited tools provided by CPT and by CMS.

During an audit, Medicare will deny or adjust E&M services that, in its judgement, exceed the patient’s documented needs.
Finally

• Per CMS – Medicare Claims Processing Manual

Medical necessity is the “overarching criterion for payment in addition to the individual requirements of the CPT code. It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower E&M 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”.

Clinical Descriptors

Most E&M code descriptions comment on the severity – a few elaborate further –
99231 “Usually, the patient is stable, recovering or improving.”
99232 “...the patient is responding inadequately to therapy or has developed a minor complication.”
99233 “Usually, the patient is unstable or has developed a significant complication or a significant new problem.”
Balancing Medical Necessity and Meaningful Use

- Bringing forward medical history in an EMR is an important aspect of meaningful use.

- Does this mean that you can count that comprehensive history toward the level of service for every office visit now and forevermore?
Medical Necessity?

Of services performed – or services billed?

Who is qualified to judge the medical necessity of a service?
How to Document Medical Necessity

Tell a story
Don’t assume level of knowledge
Don’t rely on diagnosis documentation alone
Review any payor medical polices
Reason for any services ordered-labs, EKG, Xray
CMS
“If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.”
Medical Necessity

• There has been debates among coding professionals and auditors as to whether we can judge medical necessity

• An outside auditor may judge your physician on medical necessity. Are you doing/him/her a disservice by not reviewing this?
<table>
<thead>
<tr>
<th>Nature of Presenting Problem</th>
<th>Level of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Office</td>
</tr>
<tr>
<td>Self-limited or minor problem</td>
<td>99201/99202 - 99212</td>
</tr>
<tr>
<td>Two or more self-limited or minor problems</td>
<td>99203 - 99213</td>
</tr>
<tr>
<td>One stable chronic illness</td>
<td></td>
</tr>
<tr>
<td>Acute uncomplicated illness or injury</td>
<td></td>
</tr>
<tr>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>99204 - 99214</td>
</tr>
<tr>
<td>Two or more stable chronic illnesses</td>
<td></td>
</tr>
<tr>
<td>Undiagnosed new problem with uncertain prognosis</td>
<td></td>
</tr>
<tr>
<td>Acute illness with systemic symptoms</td>
<td></td>
</tr>
<tr>
<td>Acute complicated injury</td>
<td></td>
</tr>
<tr>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>99205 - 99215</td>
</tr>
<tr>
<td>Acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td></td>
</tr>
<tr>
<td>Abrupt change in neurologic status</td>
<td></td>
</tr>
</tbody>
</table>
Presenting Problems

CMS is also quoted as saying “Medical necessity is based on the patient’s presenting problem”.

Can a presenting problem be a level 2, 3, 4 or 5?
Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- **Minimal**: A problem that may not require the presence of the physician, but service is provided under the physician'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.
Nature of Presenting Problem

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 evaluations. Chief complaint and nature of presenting problem are often used interchangeably. This describes the nature of the patient’s visit to the health care provider. Nature of presenting problem must always be reflected clearly in the documentation of the office visit. It may be nasal congestion or establishing a new health care provider. It should be a concise statement in the patient’s own words describing the problem, symptoms, condition, diagnosis, healthcare provider recommended return or some other issue.
To determine the right level of E/M code, you must:

a. Begin with the Nature of Presenting Problem and have this as the primary driver to the level of care.

b. Use the other Key Components’ criteria as specified by AMA and Medicare.

c. Refer to and build upon the Clinical examples within the CPT to get a sense of the code level’s intent.
CMS versus ER Physicians

In 2015 Noridian was auditing many of the ER groups in their region. They were targeting 99285.

I will discuss my experience with regards to their arguments and decisions that have lead me to providing this information to you today!!!!!!!
Questions

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President
Healthcare Coding Consultants, LLC