The Ins and Outs of Coding

Documenting the Medical Necessity For Podiatric Services

This key determination requires application of the proper definition.

Kenneth F. Malkin, D.P.M.

Dr. Malkin is a diplomate of the American Board of Quality Assurance and Utilization Review Physicians. He is immediate past president of the American College of Podiatric Medical Review and the Medicare Physicians Carrier Advisory Committee representative for New Jersey.

When a physician reviews a third-party payor's explanation of medical benefits, and realizes that a medical service he provided to a patient in good faith was denied as "not medically necessary," his blood boils. Physicians believe an insurer has no right to determine medical necessity – especially without reviewing a medical record. After all, neither a computer nor an insurance claim examiner has a medical degree. As always there are two sides to a story. The fact is that commercial insurers have contractual agreements with their policyholders to pay only for medically necessary care due to their agreements with policyholders. In addition, the Social Security Act states the Medicare program is restricted to paying only for "reasonable and necessary" medical care.

Physician and staff need to know how medical necessity denials are determined and attempt to avoid them, and if that fails, appeal them. There are different types of medical necessity denials and it is important to know which type of denial one is appealing. The first type is the most common. Commercial insurers make these decisions by purchasing third-party computer software containing edits that interface with their own data processing systems to analyze your claims. These computers essentially are programmed to make medical necessity denials. Often it is done by using an algorithm which examines the diagnosis code submitted on a claim and comparing it to a list of "approved" diagnoses which have been programmed to pay with the specific procedure on the claim form. Any other submitted diagnosis codes are rejected with a medical necessity denial message. For example, a submitted diagnosis code of pain may not pay for a nail avulsion procedure code. For commercial insurers these edits are a mystery. Some commercial insurers, such as Aetna, have begun posting these edits on their websites.

When considering medical necessity denials for Medicare claims, Local Medical Review Policies (LMRP's) contain all the information needed to understand the requirements expected for a specific procedure. Currently, there is a two year transition period, in which all current LMRP's will be converted to new Local Coverage Decisions (LCD's). These LCD's cannot contain coding information, and carriers are providing that information in an appendix or in a related document. The reason for this is a class-action suit in which a patient was denied coverage due to information in a LMRP. The Benefits Improvement & Protection Act of 2000 (BIPA) then mandated that beneficiaries and physicians may appeal the medical necessity aspects of a medical policy necessitating LMRP's to be converted to LCD's. Therefore, look for the coding guidelines which follow an LCD or those that are within an LMRP for the specific list of diagnoses which will pay for a specific procedure code. Remember: only those on the list of payable codes are assumed to be medically necessary. Maintaining an updated list saves a practice much aggravation.

The second type of medical necessity denial is one in which certain procedure codes are associated with claims processing edits which establish

various parameters that are required for medical necessity. For example, Medicare presumes nail debridement procedures are only medically necessary every 60 days. Submit a claim sooner and it will return as medically unnecessary. Other denial types using computers in claims processing include sex/procedure and age/procedure edits.

Pre-Approval

Requiring pre-approval for certain types of medical services is another type of medical necessity requirement. Often services such as orthotics will only be considered if accompanied by a letter of medical necessity. The physician sends a letter of medical necessity to the insurer with the expectation that the letter will be reviewed by another physician. In the real world, it is too often reviewed by a clerk who has been narrowly trained to look for specific diagnoses codes to determine if a CPT code is payable. This process is merely a waste of the provider's time, but looks good for the insurer. This is just one more hoop an insurer uses to deny medically necessary care - hoping the parties involved will not request a service due to the hassle factor.

Retrospective Review

The last category of medical necessity denials is only discovered by a detailed retrospective review of a physician's medical records. This can be a very serious type of denial that can result in requests for overpayments and sanctions by a medical board. Often this process begins with a specific patient complaint that results in an investigation which may expand to other patients. This may create a pattern of care which makes it clear that the physician is using his medical degree as a license to "print money," rather than provide patient care. The medical records may show patients without documented pathology that underwent surgery or patients subjected to a series of tests when their presenting complaints were unrelated to the services provided.

Medically Necessary Services

What constitutes a medically necessary service? There is no absolute definition of medical necessity. The current Medicare definition of medical necessity is found in Section 1862 of the Social Security Act (SSA). Essentially, Medicare will pay for 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." There are other classifications of services that Medicare will pay for in this section of the SSA, but they are out of the scope of this article.

My favorite definition of medical necessity was contained in an LMRP maintained by Pennsylvania, New Jersey, and New York Medicare carriers until it was retired. In April 2003 it was determined that language about medical necessity was contained in the Social Security Act and therefore the carrier could not create a policy of its own. This LMRP was much more illustrative and defined medical necessity as follows:

"The need for a particular item or service for the diagnosis or treatment of a disease, injury, or defect must be documented in the medical record. Furthermore, the item or service must also be:

* Appropriate for symptom and diagnosis or treatment; and
* Provided for the direct care or diagnosis of a problem; and
* In accordance with good medical standards; and
* Not primarily for the convenience of the patients or physicians ; and
* The most appropriate level of service or supply that can be safely provided to the patient."

There are two types of medical necessity - implicit and explicit. The definition of medical necessity in this LMRP states, “The rationale for a specific test or procedure must be clear in the medical record.” The rationale for certain medical services may be implicit when one reviews a medical record and other times it must be explicitly documented in the medical record. The following examples illustrate the difference.

Case One: A review of a medical record reveals that a patient presented to the office on an urgent basis with pain in her foot. The subjective portion of the medical record described that the patient dropped an iron on her right foot resulting in pain and swelling six hours before. The objective portion describes significant edema, ecchymosis, and deformity about the right fifth metatarsal with pinpoint tenderness. Radiographs of the right foot were ordered. The medical necessity for these films is implicit. There is no need to state in the record that the x-ray was ordered to rule out a fracture. Any reasonable reviewer would be able to infer the rationale. However, it is not implicit that a complete set of foot films were ordered rather than a limited set.

The exact number of views should always be documented and be consistent with the CPT code that is being billed. While it is common knowledge that a trauma patient should be evaluated with three, rather than two views, it is not assumed the physician took three. The insurer expects to pay for three views but wants documentation that they were taken. What if complete right ankle films were also taken and billed? Rationale for these films would need to be explicit as the medical necessity for this service is questionable on its face. One would expect to see elements of the medical record reflecting medical problems associated with the ankle in order for this service to be medically necessary – either in the history or exam. If a medical record merely reflected an acute foot injury, an ankle film would properly be denied as medically unnecessary.

The following are some illustrative Q & A’s

Q: What does “appropriate for symptom and diagnosis or treatment and provided for the direct care or diagnosis of a problem” actually mean in practice?

A: In the case above a foot radiograph is obviously appropriate for the symptom and diagnosis and is provided for the direct care and diagnosis of the foot trauma. This is indisputably medically necessary. Ordering a CT Scan for this acute injury before reviewing the foot films would be medically unnecessary. However if the injury turned out to be a Lisfranc dislocation as demonstrated on radiographs, a CT Scan prior to surgery would be implicitly appropriate.

Consider the case of 95-year-old nursing home resident with Alzheimer’s disease who is seen with a nail problem that is clinically suspicious for fungus. If the physician decides basic palliative care without the use of any prescription or topical anti-fungal medication is the appropriate course of therapy, why should an insurer pay for a KOH? On the other hand, if definitive treatment of the condition using an Rx topical or oral is being considered, a KOH would be medically necessary.

Consider a healthy 50 year-old male who presents as a new patient with a chief complaint of a painful tyloma. The patient reports this problem has existed for a month and no similar past complaints have ever been noted. The patient also states that he “will categorically not consider foot surgery” which may be recommended for the problem. The patient’s past medical history is completely unremarkable and he is taking no medications. The patient’s review of systems is unremarkable for any signs or symptoms of vascular insufficiency such as intermittent claudication of the legs or cold or discolored feet. The physical exam is particularly remarkable for a diffuse tyloma beneath the 5th metatarsal right foot; the patient is missing one of four pedal pulses, and has

normal skin temperature and turgor. The medical record states the physician trimmed the tyloma and padded the same on this visit. What diagnostic tests might be considered appropriate for diagnosis or treatment of this complaint?

An x-ray exam may be considered conditionally medically necessary. An x-ray would probably be considered medically necessary if the radiographs are used in conjunction with some form of a biomechanical exam to determine the proper prescription for an orthotic. Other possibly medically necessary reasons for taking an x-ray on a patient with a similar complaint may include, but are not limited to, a history of trauma, an abnormal location or appearance of the lesion, a grossly palpable unusual abnormality of the fifth met head, the presence of any cystic structures overlying the met head, and a pre-operative exam if the patient has any interest in surgery.

There are many other reasons an x-ray exam might be considered medically necessary as well. The important point is that the physician must document in the medical record specifically why a procedure was performed. One just cannot assume that an x-ray is automatically taken (and therefore medically necessary) when a non-surgical candidate presents for treatment of a tyloma. On the other hand, if the physician has no intentions of providing any other services for the patient except for paring and padding the tyloma, an x-ray may be considered "not medically necessary" because it does not change in any way the treatment plan for managing this patient's medical condition.

Q: What medical tests or procedures might be considered inappropriate for diagnosis or treatment for this patient?

A: * Non-invasive vascular studies – Some physicians may consider performing non-invasive arterial studies on this patient with very mild asymptomatic vascular disease as a baseline to compare against future studies to evaluate the deterioration of circulatory status. In reality, the studies performed at this time will have no bearing on the treatment plan for this patient who is without clinical symptoms of vascular insufficiency and therefore they will probably be denied as medically unnecessary on post-payment review. If a patient with a similar chief complaint had described symptoms of vascular insufficiency, such as intermittent claudication, rest pain, or cold feet in the review of symptoms. and also had no palpable pedal pulses and a delayed capillary refill time on exam, a vascular study would be considered medically necessary in order to diagnose the severity and extent of the clinically apparent vascular insufficiency.

* Blood glucose: If this patient denies any symptoms associated with diabetes mellitus, such as polyuria, polyphagia, polydipsia or unexplained weight loss, in the review of systems, a random blood sugar taken in the office would simply be a medically unnecessary screening test, which is clearly not covered by most insurance carriers. However, if the patient were obese and had a strong family history of Type II diabetes and also described in the review of systems symptoms consistent with diabetes, a random blood glucose would be considered medically necessary.

* Nail avulsion: This same patient has a nail avulsion performed and on post-payment review it is noted that the medical record does not document any subjective findings elicited from the patient, such as pain (and the patient is not neuropathic) nor any clinical description of the ingrown nail in the objective portion of the chart. This nail avulsion would be considered medically unnecessary and denied because it was not provided for the direct care or diagnosis of any particular problem.

Q: What does "in accordance with good medical standards" mean in practice?

A: In the previous case of the patient who dropped an iron on her foot, an x-ray is consistent with good medical standards. Some could argue that not taking an x-ray would not be within good medical standards. If your peers (podiatrists in your community) would consider your treatment plan within the range of standards for podiatric care, your services will usually be considered medically necessary.

The following is an example of “not according to good medical standards:” A physician examines a new patient with heel pain who discloses she has had no previous professional treatment for the heel pain, and is subsequently scheduled for extracorporeal shockwave therapy (ESWT) or an endoscopic plantar fasciotomy (EPF) on the next visit. The literature and medical standards document that both of these procedures are reserved for heel pain which has been recalcitrant to traditional treatment modalities. This patient has not been treated with a single conservative modality. Performing either of these services might be considered medically unnecessary at this point in the patient’s treatment protocol.

Q: What about “not primarily for the convenience of the patients or physicians and the most appropriate level of service or supply that can be safely provided to the patient?”

A: The same patient requests ESWT and does not wish to go through conservative care because of the need for multiple visits. An insurer would rightly deny the service as not medically necessary at this time because the criteria for coverage had not been met – some period of conservative care is mandatory depending on the insurer.

A different patient with severe peripheral edema asks for a lymphedema pump. The patient relates to you that support stockings are too expensive and not covered by her insurance, while her friend uses this modern machine that takes much less effort, and it cost her nothing out-of-pocket. If you order a lymphedema pump for this patient, it would be considered medically unnecessary since the pump is being prescribed solely for the convenience of the patient who is unwilling to accept a lesser and possibly more effective treatment due to out-of-pocket cost to the patient. In addition, support stockings are often required as an adjunct to the lymphedema pump in order to properly treat this intractable edema, and using a pump without a stocking would compromise the result.

An established patient presents for a physician-directed follow-up visit with a diagnosis of a lesser digital fracture. This fracture was first treated by the physician two weeks prior using a post-op shoe and a buddy splint. The patient reports a 75% improvement with almost no pain using the shoe and the taping. The patient, however, requests the doctor to provide a short leg cast instead of the post-op shoe, because the patient has learned he would be eligible for paid disability from work if he were in a cast. Applying a cast for this patient is for his convenience, making it medically unnecessary and aiding and abetting insurance fraud to the disability insurance carrier. The insurance carrier expects to pay for the most appropriate level of service, no more and no less.

Medical Necessity of E/M Services

Keep in mind that medical necessity applies to E/M services. Many physicians rely on a new patient history and physical form to document an initial H & P. As a result, each section is completed each and every time regardless of the patient’s chief complaint. This is medically unnecessary and would be considered screening. Is it logical for a new 8 year-old patient to have the level of history and exam as a 72 year-old diabetic with neuropathy and

a draining foot ulcer? Most physicians would say obviously not. The issue now becomes a question of not whether the service was provided and documented but if it was reasonable and necessary for the chief complaint. Does that mean a physician cannot use this form? Not at all; just separate what was medically necessary for the chief complaint and bill only for that service.

The bottom line: documenting medical necessity is pretty straight-forward for a prudent physician. Ask yourself if a prudent reviewer would clearly be able to follow your treatment plan and consider it reasonable. If so, you will be in the clear.

Disclaimer:

The opinions and facts contained herein are not the official position of any organization including, but not limited to, the American College of Podiatric Medical Review, the American Podiatric Medical Association, the New Jersey Podiatric Medical Society, or Podiatry Management Magazine. Coding and documentation rules are not simply black and white, and are subject to many interpretations. The various Medicare carriers differ in their medical policies for coding and documentation of the identical patient encounter. Unfortunately, there are many private insurers that maintain unique coding and documentation requirements that are in conflict with the AMA CPT Manual. The reader is urged to contact his or her local insurance carrier to discuss any statements made in this article considered controversial. In cases where variability exists, the physician must conform to the rules promulgated by the local carrier.