Medical Necessity Defends the Dollars

It's a matter of documenting "why" a treatment was rendered.

BY KARNA W. MORROW, CPC, RCC, CCS-P

Healthcare in the United States is a competitive, public, and even political landscape. Phrases such as "budget neutral" and "quality outcomes" seem to place the provider and the payor on opposite sides in the discussion of what is best for the patient. Decisions on treatment plans are frequently made both by the patient and the payor based on the available dollars. Fortunately, dollars, policies, and protocol share one common objective: Answering the question "why?" The road to reimbursement is paved by ensuring the insurance claim form can tell the story.

Each patient presents with an emotional "why?" Their life has been interrupted by pain and they want both the answer and the solution. For many, their quest will require more than a simple script and/or better footwear. Chronic conditions manifest themselves in a variety of ways that impact the simple but essential task of walking without pain.

Each provider feels the struggle to explain the "why" of a carefully crafted treatment plan to the all-powerful Oz behind the payor's reimbursement curtain. Policies are frequently defined and defended by physicians who do not share the same scope of practice or expertise. The ability to provide care to their patients requires that each provider is paid for their services in a timely fashion. No one can spend more to file the claim and chase the reimbursement than they will receive in the remit.

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And each payor needs to justify "why" to their board of directors, carefully balancing the needs of their members and the profits required to maintain a competitive edge in the marketplace. The reality of fraud in every specialty causes the payor to hold a skeptical view on the new and improved treatments that frequently cost more than the historical standard of care.

In the insurance world, "why" is translated loosely as "medical necessity"—care which meets but does not exceed the needs of the patient. If a visit once every three months will maintain the patient's mobility, why should a visit every 60 days be reimbursed? If the majority of the providers within the same geographical area manage the patient's reported condition with a level three evaluation, why should a level four or five be reimbursed for the same diagnosis? If the care provided was significant enough to support the modifier -25, why was the level of service submitted as a level two?

'Why' is a reasonable question, with answers typically stored within your electronic health record (EHR). The disconnect happens when the clinical information is incompletely translated into an ICD10-CM code(s) and unfortunately results in a CO50 denial (lack of medical necessity). The reimbursement amount may be linked to the individual procedure code, but the decision to pay or deny lies in the why.

Continued on page 34

Medical Necessity *(from page 33)*

Think about one of the most basic policies—Screening: Diabetic Foot Care Evaluation. The evaluation is considered "medically necessary" when the patient requires more than diet-controlled diabetes even in the absence of other systemic disease and physical findings. Search for a patient you have seen recently with diabetes (an insulin-dependent diabetic would be best). Find the last office visit and review the diagnosis codes assigned to the Evaluation and Management (EM) charge line. Do the codes support that expectation for medical necessity? Think about other patients for whom you've received the CO50 rejection code. Do the codes tell the story of the patient's underlying chronic conditions that directly impact the ability for that ulcer to heal? Switch to the report section of your EHR and run a report that will identify the top diagnosis codes used in the past quarter or even year. Does the volume of specific conditions and related circumstances match what you see in your practice on a daily basis?

Translating the why into a diagnosis code isn't difficult. Just avoid the "one and done." One diagnosis code rarely communicates why. One diagnosis is the patient who presents with no active problems, no underlying chronic conditions, and needs no further care. What percentage of your patients fit this description? The story (the why) for most patients requires more than a single diagnosis code. Search your diagnosis report for Z79.4 (Long-term drug therapy (use of) insulin). Search for the seventh character to describe delayed healing. What about the codes for long-term use of steroids or anti-coagulants? The path to reducing the CO50 rejections lies in your ability to use ICD 10-CM codes.

The path can be a little rocky if you've not updated the favorite list on your superbill in a few updates to the code set. Favorite lists can be efficient, but the efficiency is lost if claims are denied. Lean on the features within your EHR. Any electronic version can be updated on demand as codes and circumstance change. The EHR can assist by displaying dedicated code sets for the most frequently needed secondary or tertiary codes.

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CO50 Denials

Start with that list of CO50 denials—which claims were returned for an unfinished story? Those of most importance are those that were eventually reimbursed with additional codes from the record that had been available all along. These raise the suspicion of the payor. If the information was available, why wasn't it submitted with the initial claim, saving both sides from additional administrative burden?

The shift in focus for office-based EM services beginning in 2021 will place a stronger light on the "why." If a provider elects to report a level of care based on time, "why" did the stubbed toe require a 60-minute evaluation and review of past records? If the provider continues to document the three components of the medical decision making (MDM), "why" did the stubbed toe require bilateral x-rays and an independent review of records from an external source?

Despite mixed agendas, the primary goal is to ensure that the right provider is paid for the right services at the right rate. Ensuring that the reported diagnosis codes completely explain why will go a long way in making that goal happen in a timely manner. **PM**

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