Medical necessity from a Medicare perspective is defined under Title XVIII of the Social Security Act, Section 1862 (a) (1) (a):

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.

The subjectivity of medical necessity contributes to physician indifference and lack of willingness to embrace this imperative concept not only from an ordering of services perspective but also from the physician’s clinical documentation and E/M assignment perspective.

Consider the following points when determining medical necessity for billed E/M services:

1. Medical necessity of an E/M service is generally expressed in two ways: frequency of services and intensity of service (CPT level).

2. Medicare’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed.

3. During an audit, Medicare will deny or adjust E/M services that, in its judgment, exceeds the patient’s documented needs.

Medical necessity of an E/M service is based upon the following attributes of the service:

a) The number, acuity, and severity and/or duration of problems addressed through the history, physical, and medical decision making.

b) The context of the encounter among all other services previously rendered for the same problem.

c) The complexity of documented co-morbidities that clearly influenced physician work.

d) The physical scope encompassed by the problems (i.e., the number of physical systems affected).
Teaching Physician Statement Examples
Acceptable or Not?

*CMS Documentation Guidelines*

Transmittal 1780 states that for the purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

1.) That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and

2.) The participation of the teaching physician in the management of the patient.

Examples of minimally acceptable documentation include:

"I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

"I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

"I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

Examples of unacceptable teaching physician documentation include:

"Agree with above" followed by legible countersignature or identity

"Rounded, Reviewed, Agree" followed by legible countersignature or identity

"Discussed with resident. Agree" followed by legible countersignature or identity

"Seen and agree" followed by legible countersignature or identity

"Patient seen and evaluated" followed by legible countersignature or identity

A legible countersignature or identity alone

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.
New Subsequent Hospital Observation Codes


2011 brings a new coding option when reporting the middle day of observations that last longer than two days. Check out this expert advice on how CPT additions will affect your FP’s observation care services coding starting on Jan. 1, 2011.

Until this point, coding for the “middle days” of an observation service caused problems. Although not the norm, there are times when a physician admits a patient to observation and she remains in that status for three or more days. CPT 2011 addresses these middle days between admission and discharge by introducing three new E/M codes. The additions parallel the hospital subsequent care series in terms of component requirements and time frames:

- **99224** – Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient’s hospital floor or unit.

- **99225** — … an expanded problem focused interval history; an expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient’s hospital floor or unit.

- **99226** — … a detailed interval history; a detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient’s hospital floor or unit.

The new subsequent observation codes eliminate the confusion of how to report the middle day for observation cases that transcend three calendar days.

CMS and WPS Medicare has stated that only the physician admitting the patient to observation care status may bill the observation procedure codes. This includes the admission (99218-99220), subsequent observation (99224-99226), and discharge from observation (99217) procedure codes. Anyone else seeing the patient while in observation care would bill using an office or other outpatient procedure code 99201-99215 as appropriate.
Watch for EHR  E/M Documentation No - No’s
AAPC Coding Edge, February 2011

When using EHRs, here are the primary E/M documentation pitfalls to avoid:

- Templates and billing driving care and charting
- Point-and-click mentality vs. accurate and ethical documentation
- Copy and paste forward
  (limit the copy and paste functions - In an audit, copy and paste functions can be perceived as cloning. Copy and paste also risks introducing documentation errors. As often as possible, document in your own words.)
- Charting for services that were not performed: use of default entries
- Documentation cloning
- Negatives listed vs. positives - hard to discern what is wrong with the patient
- Failure to review available information
- Inaccurate charting
- Addendums for increased reimbursement vs. for patient care
- Relative value unit (RVU)-driven care
- Signing of notes without reading them
  (Check the meds, the test results, and all interventions with the patient; and make sure that you are in agreement with the story you have depicted of the patient’s encounter. Once you close the note, your only option for a correction is an addendum.)

Documentation Points to Remember!
- Handwritten documentation MUST be legible!
- Use of provider initials is allowed however, the best practice is use of a valid handwritten or electronic signature
- Documentation forms/templates must be used as designed!
  Example: Form instructs the use of “-” for negative and “+” for positive when documenting—Do not use circles, slashes etc. instead!

Your Partners in Compliance!

CONTACT INFORMATION:

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Please Remember!
The Compliance Training deadline for this fiscal year is June 30th!

Next Issue
Watch for our next issue in July! If you have any questions or issues you would like to see addressed in our next issue, please forward these to Karen Semperger at: karen.semperger@hc.msu.edu