Documenting Medical Necessity and 2024 Highlights

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About the Speaker

Christopher Acevedo, CHC
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Christopher is a healthcare industry veteran with over 15 years of expertise in combining the unique perspective of avoiding physician risk and liability with opportunities for optimizing reimbursement. He has returned to ACI after a 6 year hiatus where he most recently served as Vice President of Physician Operations for the Nation's largest privately held hospice as well as the Chief Operating Officer of the largest multi-state provider of palliative care services in the United States. In these roles he was responsible for day-to-day operations, strategic growth, oversight of clinical integration and excellence, financial performance and operational efficiencies. Christopher previously served as a Senior Consultant and HIPAA Specialist with Acevedo Consulting Incorporated.

Mr. Acevedo remains a highly sought after lecturer and his expertise in building highly integrated palliative care partnerships has been integral in transforming the way healthcare is delivered to the most vulnerable of patient populations.

Disclaimer

The information enclosed was current at the time it was presented. Medicare and other payer policies change frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.

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This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and compliance information, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Agenda (a/k/a *Getting paid and keeping the $$)*

- Medical Necessity
  - Defined
  - Orders
  - Determining physician supervision
  - Non-Medicare payer policies
- Highlights from the proposed 2024 MPFS Rule

Medical Necessity Defined

- Medicare law requires that in order for expenses incurred for items or services to be covered, they must be “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”
- CMS Glossary for Beneficiaries defines medical necessity as: “Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren’t mainly for the convenience of you or your doctor.

Medical Necessity Defined*

In order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective;
- Not experimental or investigational (exception: routine costs of qualifying clinical trail services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis of treatment of the patient's condition or to improve the function of a malformed body member;
  - Furnished in a setting appropriate to the patient's medical needs and condition;
  - Ordered and furnished by qualified personnel;
  - One that meets, but does not exceed the patient's medical need; and
  - At least as beneficial as an existing and available medically appropriate alternative.

*Ch. 3, Program Integrity Manual

Service meets, but does not exceed the patient's medical need

- Medicare and non-Medicare payers' medical necessity definitions includes this requirement. Examples:
  - Steroid injection before viscosupplementation
  - Fosamax before Prolia

Beware EMR macros:

"Patient with continued bilateral knee pain interfering with ADLs for more than 3 months, from Osteoarthritis. No improvement after home exercises, physical therapy, NSAIDs and steroid injections."

The Why:

Payer knows if the patient has had PT, steroid injection(s) and imaging to support OA based on claims data.

Medical Necessity of Services

- Medical necessity is evidenced not only by correct ICD-10 coding on the claim, but also by documentation in the patient's medical record supporting the diagnosis and need for the test.
- Documentation must support the treating physician's use of the diagnostic test in the patient's care.
- Documentation must support the completion and interpretation of the test.
  - How do your doctors document their I&R of x-rays or MSK u/s?
  - Is there a formal Interpretation & Report?

Medical Necessity of Services

- Advanced imaging must be used in accordance with standard of medical practice
  - Appropriate Use Criteria is on hold for now
    - Proposed 2024 MPFS rule revokes this regulation
- Frequency of services must be medically necessary based on initial inconclusive results, need for further diagnostic testing, measurement of efficacy of treatment.
- If subsequent or repeat testing is required, documentation must support the reasons why the initial tests were insufficient or why the serial progression of test was required.
  - Documentation must show how repeat lab test findings influence the prescribed treatment plan (e.g., side effects of Mtx).

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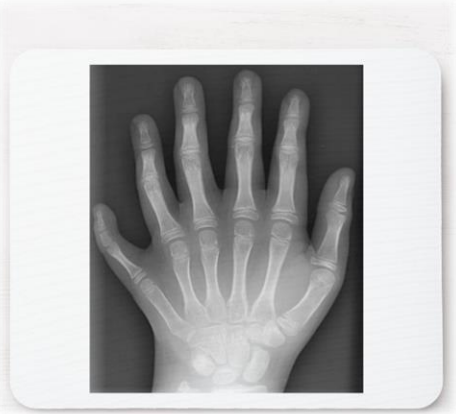
Orders

Medical Necessity: Order Documentation Requirements

- Code of Federal Regulations (CFR) § 410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions
  - *(a)Ordering diagnostic tests*

    All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.



Medical Necessity: Documentation Requirements (continued)

- The physician who is treating the beneficiary must order all diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests. The physician who is treating the beneficiary is the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.
- When completing progress notes, the physician should clearly indicate all tests to be performed (for example, "run labs" or "check blood" by itself does not support intent).

Medical Necessity: Documentation Requirements (continued)

- Documentation in the patient's medical record must support the medical necessity for ordering the service(s) per Medicare regulations and applicable Local Coverage Determinations (LCDs). Submit these medical records in response to a request for medical records.
- Keep these records available upon request:
  - Progress notes or office notes;
  - SIGNED Physician order/intent to order;
  - Laboratory results; and/or
  - Attestation/signature log for illegible signature(s).

Order and/or Documentation of Intent

- An "order" is a communication from the treating physician/practitioner requesting that a diagnostic test or therapeutic service be performed.
- While an order is not required to be signed, the physician must clearly document, in the medical record, his/her intent that the test be performed.
  - And that entry must be signed

Documenting an Order or Intent

- Acceptable documentation may include:
  - Properly signed progress note indicating reason and test(s) desired
  - (secure) Email from treating physician requesting test and reason for such.
    - If email used as intent/order the email would need to be properly signed by the requesting physician.

EMR Challenges

- "Re-check labs" in an e-signed progress note is not an order
  - Does not specify the lab tests
- Look for the order entry section of the EMR…..
  - Shows exactly what was ordered – each test – and the physician/NPP's name – but it's not possible to sign this "order."
- Can't you use a signature Attestation?
  - No, not for diagnostic test orders
- Bottom line – there must be a signed order or signed intent for each diagnostic test performed and billed.

Impact on Office Visit Documentation & Coding

- 3 Elements of MDM
  1. Number/Complexity of problems addressed
  2. Amount/complexity of the data reviewed and analyzed
  3. Risk of complications, mortality, morbidity of patient management.

Office Visit Documentation & Coding

Amount/complexity of the data reviewed and analyzed

- Each “unique test” ordered is considered in this element
- Unique test is determined by the CPT® code
- CBC, Culture, MRI = 3 unique tests
- “Labs” “tests” “workup” = nothing!

Office Visit Documentation & Coding

Example for impact on E/M coding:

OA w/increasing knee pain (Moderate/L4) +
"Repeat workup" (minimal/none/L2) +
Advised to take extra strength Tylenol for now.
(OTC/Low/L3)
= 99213

VS.

OA w/increasing knee pain (Moderate/L4) +
"CMP, CBC, CRP" (Moderate/3 tests/L4) +
Advised to take extra strength Tylenol for now
(OTC/Low/L3)
= 99214

And if the payer is not Medicare…

United Healthcare Policy Number 2023R9017C

Documentation Requirements for Reporting Laboratory Services

According to CMS, the physician or other qualified health care professional who is treating the patient must order all diagnostic laboratory tests, using these results in the management of the patient's condition. Tests not ordered by the physician or other qualified health care professional are not reasonable and necessary and may not be considered for reimbursement.

The physician's or other qualified health care professional's documentation should clearly indicate all tests to be performed. For example, "run labs" or "check blood" by itself does not support intent to order.

Documentation of an order or intent to order may include for example:

- A signed order or requisition listing the specific test(s), or
- An unsigned order or requisition listing the specific test(s), and an authenticated medical record (e.g., progress notes or office notes) supporting the physician's intent to order the tests (for example, "order labs", "check blood", "repeat urine," or
- An authenticated medical record (e.g. office notes or progress notes) supporting the physician intent to order specific test(s), or
- Electronic requisitions are acceptable when the laboratory can demonstrate the order(s) was received through a standardized electronic process.

The medical record should include the documentation described above, as well as a copy of the test results.

For additional information, refer to the Questions and Answers section, Q&A #7

Tips to Avoid Denials and Recoupment

- Did the ordering physician sign the document?
  - Cannot use signature attestations for diagnostic tests
- Be specific
  - "Will get labs" vs. "CBC, CMP, CRP"
- Be familiar with the payer's clinical/reimbursement policies and document accordingly
- Make sure your note/order clearly states the "why";
  - Especially for repeat tests

Tips To Avoid Medical Necessity Denials

Think of it this way:

- A diagnostic test should answer a clinical question you have about the patient's signs, symptoms or condition.
- Does the doctor's/NPP's documentation….
  - reflect that question , and
  - what they did with the answer?

2024 Proposed MPFS Rule Highlights

2024 Proposed MPFS Rule Highlights

- Setting 2024 Medicare payment rates for physician services. For 2024, CMS proposes a Conversion Factor of $32.7476
- Extending flexibilities to permit split/shared E/M visits to be billed based on one of three components (history, exam, or medical decision making) or time through at least 2024,
- Reimbursing telehealth services furnished to patients in their homes at the typically higher, non-facility PFS rate;

2024 Proposed MPFS Rule Highlights

- Continuing to allow direct supervision by a supervising practitioner through real-time audio and video interaction telecommunications through 2024;
- Continuing coverage and payment of telehealth services included on the Medicare Telehealth Services List through 2024;
- Increasing the performance threshold from 75 points to 82 points for all three MIPS reporting options;

Proposed 2024 MPFS Rule

Drugs and Biologicals which are Not Usually Self-Administered by the Patient, and Complex Drug Administration Coding

- CMS is soliciting comments regarding our policies on the exclusion of coverage for certain drugs under Part B that are usually self-administered by the patient. In addition, we are seeking comment on coding and payment policies for complex non-chemotherapeutic drugs, in an effort to promote coding and payment consistency and patient access to infusion services.

Proposed 2024 MPFS Rule

Appropriate Use Criteria

CMS is proposing to pause efforts to implement the Appropriate Use Criteria (AUC) program for reevaluation and to rescind the current AUC program regulations at 42 CFR414.94. CMS will continue efforts to identify a workable implementation approach and will propose to adopt any such approach through subsequent rulemaking.

2024 Proposed MPFS Rule

CMS is proposing several regulatory provisions regarding Medicare and Medicaid provider enrollment. These include, but are not limited to, the following:

- Creation of a new Medicare provider enrollment status labeled a “stay of enrollment,” which CMS believes will ease the burden on providers and suppliers while strengthening Medicare program integrity.
- Requiring all Medicare provider and supplier types to report additions, deletions, or changes in their practice locations within 30 days.
- Establishing several new and revised Medicare denial and revocation authorities.
- Clarifying the length of time for which a Medicaid provider will remain in the Medicaid termination database.

2024 Proposed MPFS Rule

E&M Add-on Code G2211

- We are proposing refinements to the policy, however, after considering information from interested parties who shared feedback in earlier rulemaking about our utilization assumptions and the estimated redistributive impact of the code on PFS payments. These changes have reduced the redistributive impacts of this policy. Specifically, we are proposing that the add-on code would not be billed with a modifier that denotes an office and outpatient evaluation and management visit that is itself unbundled from another service (e.g., a procedure where complexity is already recognized in the valuation). Second, we have refined our utilization estimates for HCPCS code G2211 in response to public feedback. These refinements collectively reduce the redistributive impact to the CY 2024 CF by nearly one third of the estimated impact described in the CY 2021 Medicare Physician Fee Schedule final rule.

Proposed 2024 MPFS Rule

G2211:

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

- …we are proposing that the O/O E/M visit complexity add-on code, HCPCS code G2211, would not be payable when the O/O E/M visit is reported with payment modifier-25.

QUESTIONS

About Acevedo Consulting Incorporated

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