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Understanding Medical Necessity

By Jennifer Swindle

Paper or EHR templates that have sections for all E&M elements may lead to over documentation, a potential compliance risk.

What is medical necessity, and how is it applied to evaluation and management (E&M) services?

Answer: The definition of medical necessity is sometimes complicated, and most payers use slightly different wording. However, a Centers for Medicare & Medicaid Services contractor defined medical necessity in a 2002 bulletin as follows: "The need for an item(s) or service(s) to be reasonable and necessary for the diagnosis or treatment of disease, injury, or defect."

Medicare and other payers will not cover services that are not determined to be medically necessary. This is a deciding factor for claims payment; however, not all payers follow the same rules.

Many local coverage determinations and national coverage determinations identify when services are reasonable and necessary, including what diagnostic codes support the service and the appropriate frequency. Therefore, medical necessity is defined by payer policies for many procedures and services.

However, defining medical necessity for E&M services is not as clear and often comes under fire. Clinicians and coders should be careful to include only those things that are necessary for patient treatments to determine the appropriate levels of E&M services.

Over documentation, and particularly cloned documentation—notes copied from one source in an electronic health records (EHR) to another location in the EHR—can sometimes cause problems because the original source documentation may support higher service levels than what is medically necessary for new patient cases. The *Medicare Claims Processing Manual* says:

> [Medical necessity is the] overarching criterion for payment in addition to the individual requirements of a CPT code. The level of service should not be based just on volume of documentation. Documentation should be captured based on what was necessary to perform reasonable and appropriate care of the patient's current problem(s).

Most often, risks occur during a review of systems, when a positive healthcare finding is documented but the entire review of systems is otherwise negative. Consideration must be given to whether it was necessary to do a complete review of systems.

For example, if a patient presents with a head cold, is it medically necessary to query about the musculoskeletal system or genitourinary system to determine the best course of treatment? If not, it may not be appropriate to capture a complete review of systems.

Many EHR systems allow for normal exams to be selected and will auto-fill all normal exam elements, which may include comprehensive exams. Providers need to remove all incomplete sections, as well as update records with any abnormal findings. If patients present with a minor health problem, comprehensive exams may not be considered medically necessary. The primary rule should be to perform what is necessary to appropriately assess, diagnosis, and treat patients for the condition(s) presented during the visit and document all services that were performed.

It is unlikely that comprehensive histories and examinations are necessary or appropriate for all patients. Templates—either in paper records or EHRs—that have blanks or sections for all elements that may be captured for E&M services may lead providers into over-documentation, which can be a compliance risk. It is important that all providers understand that medical necessity should drive the level of service.

Jennifer Swindle, RHIT, CCS, CCS-P, CPC, CIC, CPMA, is vice president, coding solutions, Salud Revenue Partners, LLC, Lafayette, Ind., and a member of HFMA's Indiana Pressler Memorial Chapter (jswindle@saludrevenue.com).