

Coding for Medical Necessity

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MHA631
Health Insurance

Lecture 8



Objectives

- Explore Applying Coding guidelines.
- Discuss Coding and Billing Considerations.
- Examine Coding from Patient Reports.

Applying Coding Guidelines

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Applying Coding Guidelines

- Be sure to code and report only those diagnoses, conditions, procedures, and/or services that are documented in the patient record as having been treated or medically managed.
- **Medically managed** means that even though a diagnosis (e.g., hypertension) may not receive direct treatment during an encounter, the provider has to consider that diagnosis when determining treatment for other conditions. It is appropriate to code and report medically-managed diagnoses and conditions.

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Applying Coding Guidelines

- Questions that should be considered before coding and reporting a diagnosis or condition include:
 1. Does the diagnosis or condition support a procedure or service provided during this encounter?
 2. Did the provider prescribe a new medication or change a prescription for a new or existing diagnosis or condition?

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Applying Coding Guidelines

3. Are positive diagnostic test results documented in the patient record to support a diagnosis or condition?
4. Did the provider have to consider the impact of treatment for chronic conditions when treating a newly diagnosed condition?

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Applying Coding Guidelines

- When reporting procedure/service codes on the CMS-1500, it is important to carefully match the appropriate diagnosis code with the procedure or service provided.
- Providers often document past conditions that are not active problems for the patient, and these conditions are not coded or reported on the claim.

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Applying Coding Guidelines

- Report ICD-9-CM codes on the claim, beginning with the **first-listed diagnosis** and followed by any **secondary diagnoses** (e.g., coexisting conditions) that were treated or medically managed.
- Then, link the code for each procedure or service provided with the diagnosis or condition that proves the **medical necessity** for performing the procedure or service.

Coding and Billing Considerations

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Coding and Billing Considerations

- In addition to applying coding guidelines and rules to accurately assign and report codes on insurance claims, you should also incorporate the following as part of practice management:
 - Completion of an Advance Beneficiary Notice (ABN) when appropriate.
 - Implementation of an auditing process.
 - Review of local coverage determinations (LCDs) and national coverage determinations (NCDs).
 - Complete and timely patient record documentation.

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Coding and Billing Considerations

- **Patient record documentation** must justify and support the medical necessity of procedures and services reported to payers.
- The following characteristics are associated with patient record documentation in all healthcare settings:
 - Documentation should be generated at the time of service or shortly thereafter.

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Coding and Billing Considerations

- Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, correction of errors, addition of information not initially available, and when certain unusual circumstances prevent documentation at the time of service.
- Delayed entries cannot be used to authenticate services or substantiate medical necessity for the purpose of reimbursement.

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Coding and Billing Considerations

- The patient record cannot be altered. Doing so is considered tampering with documentation.
- This means that errors must be legibly corrected so that a reviewer can determine the origin of the corrections, and the use of correction fluid (e.g., Wite-Out™) is prohibited.

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Coding and Billing Considerations

- Corrections or additions to the patient record must be dated, timed, and legibly signed or initialed.
- Patient record entries must be legible.
- Entries should be dated, timed, and authenticated by the author.

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Coding and Billing Considerations

- An **Advance Beneficiary Notice (ABN)** is a waiver required by Medicare for all outpatient and physician office procedures/services that are not covered by the Medicare program.
- Before providing a procedure or service that is not medically necessary and/or that Medicare will not cover, the patient must be informed and required to sign the waiver. (Even though a provider considers a procedure or service medically necessary, Medicare may not cover that procedure or service.)

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Coding and Billing Considerations

- Patients sign the waiver to indicate that they understand the procedure or service is not covered by Medicare and that they will be *financially responsible* for reimbursing the provider for the procedure or service performed.

Coding and Billing Considerations

EXAMPLE: A Medicare patient is seen by her healthcare provider for severe left shoulder pain. There is no history of trauma, and in the office the patient has full range of motion with moderate pain. The patient insists that she wants the shoulder scanned to make sure she does not have cancer. Her physician explains that Medicare will reimburse for a scanning procedure *only if medically necessary* and that her symptoms and past history do not justify his ordering the scan.

Coding and Billing Considerations

The patient insists again that she wants the scan even if she has to pay for it herself. The physician explains that this is an option for her and that she can sign the facility's ABN so that if Medicare denies the claim, the facility can bill her for the scan. The patient signs the ABN, which the physician keeps on file in the office, and the scan is ordered. The claim is submitted to Medicare, but it is denied due to lack of medical necessity to justify the scan. The patient is billed for the scan and is responsible for reimbursing the facility.

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Coding and Billing Considerations

- Medical practices and healthcare facilities should routinely participate in an **auditing process**, which involves reviewing patient records and CMS-1500 claims to assess coding accuracy and completeness of documentation.
- Physicians use an encounter form (or superbill) to select diagnoses treated or medically managed and procedures, services, and supplies provided to patients during an office visit.

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Coding and Billing Considerations

- CMS develops **national coverage determinations (NCDs)** on an ongoing basis, and Medicare administrative contractors create edits for NCD rules, called **local coverage determinations (LCDs)**.
- NCDs (and LCDs) link ICD-9-CM diagnosis codes with procedures or services that are considered reasonable and necessary for the diagnosis or treatment of an illness or injury.

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Coding and Billing Considerations

- When review of NCDs (or LCDs) indicates that a procedure or service is *not medically necessary*, the provider is permitted to bill the patient **only if** an Advance Beneficiary Notice (ABN) is signed by the patient prior to providing the procedure or service.

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Coding and Billing Considerations

- **Local coverage determinations (LCDs)** specify under what clinical circumstances a service is covered (including under what clinical circumstances it is considered to be reasonable and necessary) and coded correctly.
- They list covered and noncovered codes, but they do not include coding guidelines.

Coding from Patient Reports

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Coding from Patient Reports

- A **patient record** serves as the business record for a patient encounter, and is maintained in a manual record or automated format (e.g., electronic medical record).
- The patient record contains documentation of all healthcare services provided to a patient to support diagnoses, justify treatment, and record treatment results.

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Coding from Patient Reports

- The primary purpose of the patient record is to provide **continuity of care** (documentation of patient care services so that others who treat the patient have a source of information from which to base additional care and treatment).
- **NOTE:** Health insurance specialists review the patient record when assigning codes to diagnosis, procedures, and services. In addition, copies of reports from the patient record may be requested from third-party payers to process insurance claims.

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Coding from Patient Reports

- Diagnoses, procedures, and services are selected and coded from clinic notes, consultation reports, and diagnostic reports.
- **Clinic Notes**
- Healthcare providers use two major formats for documenting clinic notes:
 - Narrative clinic notes.
 - SOAP notes.

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Narrative Clinic Note

- A narrative clinic note is written in paragraph format.

EXAMPLE: Narrative clinic note

A 21-year-old female patient comes to the office today, having been referred by Dr. Bandaïd for pain in the RLQ of the abdomen, 2 days' duration. Temp: 102°F. Detailed history and physical examination revealed rebound tenderness over McBurney's point with radiation to the RUQ and RLQ. The remainder of the physical examination is normal. For additional information see the complete history and physical in this chart. Laboratory data ordered by Dr. Bandaïd (oral report given by Goodtechnique Lab) is as follows: WBC 19.1; RBC 4.61; platelets 234,000; hematocrit 42; hemoglobin 13.5; bands 15%, and PMNs 88%. UA and all other blood work were within normal limits. Patient is to be admitted to Goodmedicine Hospital for further work-up and possible appendectomy.

T.J. Stitcher, M.D.

SOAP Notes

- **SOAP notes** are written in outline format:
- Subjective,
- Objective,
- Assessment, and
- Plan.

SOAP Notes

- The **subjective** part of the note contains the chief complaint and the patient's description of the presenting problem.
- It can also include the response to treatment prescribed earlier, past history, review of symptoms, and relevant family and social history.
- The documentation may appear in quotes because it represents the patient's statement verbatim.

SOAP Notes

- The **objective** part of the note contains documentation of measurable or objective observations made during physical examination and diagnostic testing.
- Some healthcare providers may also include historical information obtained from previous encounters in this section.

SOAP Notes

- The **assessment** contains the diagnostic statement and may include the physician's rationale for the diagnosis.
- If this section is missing from the report, look for positive diagnostic test results documented in the objective data or code the symptoms presented in either the subjective or objective data.

SOAP Notes

- The **plan** is the statement of the physician's future plans for the work-up and medical management of the case.
- This includes:
 - plans for medications,
 - diet, and therapy,
 - future diagnostic tests to be performed,
 - suggested lifestyle changes, and
 - suggested follow-up care.

SOAP Notes

EXAMPLE: SOAP note

3/29/YYYY

- S: Pt states “no complaints, no new symptoms since last visit, which was seven days ago.”
- O: Patient seen today, on 10th day postop. T 98.6°F; P 80; R 20; BP 120/86, right arm, sitting, WT 120 lb.
Incision, inner aspect of left breast, healing well. No sign of inflammation or infection.
- A: Papilloma with fibrocystic changes, no malignancy.
Size 3.0 x 1.5 x 0.2 cm.
- P: 1. Suture removal today.
2. Return visit, 3 months for follow-up.

Janet B. Surgeon, M.D.

Cases about SOAP Notes

SOAP Notes

- "No headaches, feeling normal."
- BP 125/80, Pulse 72. Weight 150 lbs.
- Stable hypertension.
- 1. Continue medication.
2. Check BP daily.

- **Subjective (S)**

- **Objective (O)**

- **Assessment (A)**

- **Plan (P)**

SOAP Notes

- "No fever after the shot."
- No redness at injection site. Temp 98.6°F.
- Normal vaccine reaction.
- 1. No action needed.
2. Next vaccine in 6 months.

- **Subjective (S)**
- **Objective (O)**
- **Assessment (A)**
- **Plan (P)**

Key Takeaways

1. Medically managed means that even though a diagnosis may not receive direct treatment during an encounter, the provider has to consider that diagnosis when determining treatment for other conditions.
2. Patient record documentation must justify and support the medical necessity of procedures and services reported to payers for reimbursement.
3. Medical practices and healthcare facilities should routinely participate in an auditing process, which involves reviewing patient records and CMS-1500 to assess coding accuracy and completeness of documentation.

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Key Takeaways

4. National coverage determinations (NCDs) and local coverage determinations (LCDs) specify under what clinical circumstances a service is covered, and they list covered and noncovered codes.
5. Healthcare providers document narrative clinic note and SOAP note.



Thank You