CODING Q&A

Medical Necessity in E/M Coding

DAVID STERN, MD, CPC

Over the next few issues of *JUCM*, we will look at each aspect of E/M documentation from the viewpoint of medical necessity. These columns may be useful as a resource for auditors and urgent care administrators to evaluate issues of medical necessity when auditing charts of urgent care providers for E/M coding.

Q. Recently some of my charts were audited and the payor challenged the levels of the evaluation and management (E/M) codes I had used. The payor said that the charts were actually coded correctly, based on the information that was documented on the chart. The auditor, however, challenged what she called the "medical necessity" of the documentation. She claimed that, based on the patients' chief complaints, many elements of the E/M that were documented were not indicated for each patient. Is this correct?

A. Medical necessity is an area that is being more frequently challenged by auditors. The Centers for Medicare & Medicaid Services (CMS) has noted that physicians should consider medical necessity as the primary issue in E/M coding. ■

Q. What is the definition of medical necessity?

A. AMA (Policy H-320.953[3], *AMA Policy Compendium*) defines medical necessity as:

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.

David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Dr. Stern speaks frequently at urgent care conferences. He is CEO of Practice Velocity (*www.practicevelocity.com*), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

CMS ("Medicare Claims Processing," Pub. 100-04 *CMS Manual System*, Transmittal 178, May 14, 2004) has given the following guidance on medical necessity in relationship to E/M coding:

> *Medical necessity* of a service is the *overarching criterion* for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record. (Italics added.) ■

Q. My charts are going to be reviewed in a Recovery Audit Contractors (RAC) audit. Do RAC audits include reviews of the level of E/M services on physician claims under Medicare Part B?

A. RAC coding reviews currently look at E/M codes that should not be billed because they are already included in the global payment for a procedure. However, RAC reviews do *not* currently involve auditing the actual level of E/M codes. ■

Q. What elements are appropriate for a provider to perform and document in the history of present illness (HPI) for a typical urgent care visit?

A. It is difficult to answer this question in the abstract, so let's look at a typical urgent care complaint. What elements of the HPI are appropriate for a patient who presents with, for example, a sore throat?

- *Location.* This is recorded by definition in the documentation of sore throat.
- *Quality.* Is the pain merely itching or scratchy, is it burning or sharp, or is it a foreign body sensation? This is important to differentiate probable diagnoses of a viral or bacterial etiology or a foreign body (eg, a bay leaf that was swallowed and has lodged in the throat).
- *Severity.* Sore throats of a rhinovirus etiology are often de-

scribed as milder than sore throats caused by group A streptococci or infectious mononucleosis.

- *Duration.* Sore throats that have been present for several months are much less likely to be caused by group A streptococci than sore throats caused by an ulcer or a tumor.
- *Timing.* In most cases, documenting whether the sore throat is worse in the morning, evening, or at other times of the day is not likely to meet the criteria for medical necessity.
- *Context.* Has the patient been exposed to an individual suffering from influenza, strep throat, or infectious mononucleosis? A positive answer to any of these questions will highly influence the weighting of the differential diagnosis.
- *Modifying factors.* In order for the physician to suggest appropriate symptomatic treatment, it is helpful to know which symptomatic treatments (eg, ibuprofen, acetaminophen, salt water gargles, etc.) the patient has tried and how he/she has responded to these treatments.
- *Associated signs and symptoms.* Significant fevers are associated with an increased likelihood of strep infection. Light-headedness might indicate dehydration. Ear pain or tooth pain might indicate that the throat pain is referred from another anatomic location.

Thus, almost all elements of the HPI (with the possible exception of timing) meet the criteria for medical necessity, even for a patient presenting with a sore throat—a complaint that is extremely common in urgent care and usually not associated with a poor outcome. Only four of eight elements of the HPI are required for an extended HPI. As such, an extended HPI meets the criteria for medical necessity for the vast majority of urgent care patients. ■

Disclaimer: JUCM *and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.*