MASTERING MEDICAL NECESSITY

How to Frustrate Payer Audits with Your Undeniable Excellence

GLENN KRAUSS

Table Of Contents

Preface 2
What are The Key Ingredients for Medical Necessity 5
What is a Chief Complaint 7
Example of an Insufficient Chief Complaint 7
Example of a Sufficient Chief Complaint 8
What is The History and Physical (H&P) 9
What is The History of Present Illness 11
Examples of the Chief Complaint & HPI 11
What is The Physical Exam 14
Examples of the Physical Exam 14
What is The Assessment 17
Examples of the Assessment 17
What are The Comorbidities 19
Examples of the Comorbidities 20
What is The Analytical Assessment Process 21
Examples of The Analytical Assessment 22
What is The Assessment 23
What is The Statement of Complexity & Clinical Judgement 24
What is The Two Midnight Rule Expectation 25
Examples of Documentation for the 2MN Rule Expectation 27
A Call to Action 29

Preface

The COVID-19 pandemic is placing undue monumental financial stressors upon hospitals with added costs to treat patients with high acuity and long length of stays coupled with significant revenue loss associated with postponement of more profitable elective surgeries like joint replacements and other day surgeries. The cost of halting major elective surgery during the pandemic is estimated to be $22.3 billion for U.S. hospitals, according to a new study published in the Annals of Surgery.

An AHA report released in June 2020 highlighted that the financial strain facing hospitals and health systems due to COVID-19 would continue through at least 2020, with total losses expected to be at least $323 billion in 2020. The report estimated an additional minimum of $120.5 billion in financial losses, due in large part to lower patient volumes, from July 2020 through December 2020, or an average of $20.1 billion per month.

Adding even more financial duress to hospitals is the fact that payers are steadfastly issuing more provider denials in the name of cost containment and protecting of their profits. The average rate of denials has increased by 23 percent in 2020 compared to four years ago, according to a recent report by Change HealthCare.

Key points highlighted in The Change Healthcare 2020 Revenue Cycle Denials Index include the following:

- The average denials rate is up 23% since 2016, topping 11.1% of claims denied upon initial submission through the third quarter of 2020.
- Since the onset of COVID-19, denials have risen 11% nationally.
- 86% of denials are potentially avoidable; nearly a quarter (24%) of these are not recoverable. .
- 95-100% of non-recoverable denials can likely be avoided.

The conclusion: Revenue loss is occurring that is preventable.

Wouldn't "Denials Prevention" be a better and more logical approach than simply "Managing Denials"?

Most hospitals address payer denials through the denial's management process, evaluating and appealing each claim repetitively as they are received, reactionary and transactional in nature. This denials appeals process is highly segmented, costly, and highly inefficient over time. A more efficient logical means to managing denials is to develop and implement a more proactive preemptive approach that fundamentally is predicated upon denials avoidance, alleviating most of the costly self-inflicted medical necessity and clinical validation denials as well as DRG and level of care downgrades.

These categories of denials are unequivocally associated with insufficient and/or poor physician documentation beginning in the Emergency Room documentation and continuing with the History and Physical, the segue to entry into the hospital where effective and complete physician documentation is paramount to establishment of medical necessity for inpatient level of care.

Time and time again many a medical necessity denial is caused by poorly executed History & Physicals devoid of clinical information, clinical facts and clinical context in the documentation that accurately reports, reflects, depicts, describes, and tells the patient's true clinical story closely approximating the patient's severity of signs and symptoms, medical predictability of an adverse event and need for hospital level of care.

The good news is that mastery of documenting medical necessity for any level of care is easily within reach. Hence, this ebook...

There is no certification in the industry for documenting the medical necessity of any level of patient care. And there is no need, because quite simply, it is not worthy of such. Nevertheless, there is the need to understand the "recipe" if you will, that produces the necessary written documentation to validate the need for medical care.

Effective and complete documentation can be considered in the following context, recognizing that **documentation is the recording of information** by individuals involved in providing clinical health services and that it **is the most reliable indicator of the care that has been provided.**

What are The Key Ingredients for Medical Necessity

Clinical documentation improvement initiatives require heightened attention to detail, reviewing every record with a keen eye to detail and the ability to identify true insufficiencies in physician documentation. One must incorporate the ability to recognize potential opportunities for real meaningful improvement in the accuracy and completeness in physician documentation that directly impacts the ability of the medical record to effectively communicate patient care.

Complete and accurate physician documentation begins in the Emergency Room, moves onto the History and Physical, continues with the progress notes and culminates in the discharge summary. Any breakdown in clear, concise, consistent, and contextually correct documentation potentially detracts from achievement of quality focused, patient centered, cost effective, outcomes based, patient care supportive of optimal compliant reimbursement.

Focusing primarily upon identification of and querying for diagnoses that impact reimbursement and/or quality scores for the hospital fail to capitalize upon the opportunity to work with physicians as constituents and colleagues to achieve measurable sustainable improvement in documentation directly impacting patient care and securement of a high performing revenue cycle.

In the sections below, we'll identify each of these Key Ingredients:

1. The Chief Complaint
2. The History & Physical (H&P)
3. The History of Present Illness (HPI)
4. The Physical Exam
5. The Assessment
6. The Comorbidities
7. The Analytical Assessment Process
8. The Statement of Complexity & Clinical Judgement

Then we discuss the Two Midnight Rule Expectation.

And finally, we'll end with a Call to Action for all CDI Specialists.

What is a Chief Complaint

Every patient encounter should have a documented chief complaint.

A chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words. For example, patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly reflect the CC.

Often the Chief Complaint is not adequate, is nonexistent or is not in the patient's own words. Examples of these include the following:

Example of an Insufficient Chief Complaint

- Patient is doing better, Patient has no new complaints, No new events overnight
- Patient seen in follow-up
- Acute hypoxemic respiratory failure
- Impending MI
- Acute blood loss anemia
- Hemorrhagic stroke, Ischemic stroke
- Aspiration pneumonia with metabolic encephalopathy

Example of a Sufficient Chief Complaint

- Cough that won't go away for the last week
- Feels like an elephant sitting on my chest
- Can't catch my breath
- Worse headache I ever had
- Feel weak and tired, I fell last night
- Abdominal pain, feels like a knife in my abdomen

What is The History and Physical (H&P)

The History and Physical or outpatient encounter note should contain a clinically relevant History of Present Illness congruent with the nature of the patient's presenting problem. There are eight elements to a HPI and far too often the intent of the HPI, that is a chronological account and description of the patient's signs/symptoms and problems, is not well documented when accounting for the nature of presenting problem.

There are three key components to the History & Physical consisting of History, Physical Exam and Medical Decision Making.

The History is broken down into subcomponents of History of Present Illness, Review of Systems and Past/Family/Social History.

Let's focus upon the History of Present Illness, a major limiting factor in many records that significantly detracts from establishment of medical necessity for hospital level of care, regardless of whether inpatient or observation designated level of care. An adequate History of Present Illness that accurately describes, tells, depicts, displays, and reflects a clear patient story of severity of illness and need for hospital level of care must contain at least four elements of an HPI. HPI is a chronological description of the development of the patient's present illness from the first sign and/ or symptom or from the previous encounter to the present.

There are eight distinct elements of a History of Present Illness as follows:

- **Location** (example: left leg)
- **Quality** (example: aching, burning, radiating pain)
- **Severity** (example: 10 on a scale of 1 to 10)
- **Duration** (example: started 3 days ago)
- **Timing** (example: constant or comes and goes)
- **Context** (example: lifted large object at work)
- **Modifying factors** (example: better when heat is applied)
- **Associated signs and symptoms** (example: numbness in toes)

A large majority of medical necessity denials and/or level of care downgrades from inpatient to observation are based upon insufficient History of Present Illness that clearly depict the patient's severity of signs and symptoms and medical predictability of an adverse event supporting the physician's clinical judgment and medical decision making for the need for inpatient level of care.

The History of Present Illness should answer the following questions in full with the reader able to clearly understand and grasp without any reasonable doubt:

- What is wrong with the patient?
- What does it look like?
- How did it manifest?

Examples will be included in the next section about the History of Present Illness (HPI).

What is The History of Present Illness

The History of Present Illness should remain focused upon the present illness versus the past illness, including clinically relevant history in the HPI that are directly related to the patient's chief complaint and presenting signs and symptoms while including other pertinent history in the Past Family Social History part of the note.

Examples of the Chief Complaint & HPI

Example #1:

Chief Complaint: Impending MI

History of Present Illness:

Mrs. Jones, a poor 75-year-old woman well known to me, presented to the Emergency Department this morning by ambulance at approximately2 AM with chief complaint of chest pain. She has a history of diabetes, colon cancer s/p colectomy with adjuvant radiation therapy, peripheral neuropathy, stroke, pulmonary embolism, CAD with MI, CABG X 2, and history of toe amputation due to ischemic toe, otherwise healthy. Patient received usual MI workup in ED, still complaining of chest pain after IV Morphine and nitro with O2 supplement and decision was made to observe the patient in the hospital for further workup and management.

Example #2: (better example)

Chief Complaint: Chest pain that just won't stop

History of Present Illness:

Mrs. Jones, well known to me with a complicated past medical history presented to the Emergency department this morning at 2 AM with chest pain, she recently presented to the ED four days ago with chest pain, worked up for MI and determined to be another anxiety attack, she recently lost her husband to colon cancer and seems to be lonely and depressed from his death. Yesterday, she had another episode of chest pain, took 2 of her nitro that she uses to manage her angina, and her chest pain subsided. At around 11 PM, her chest pain returned not responsive to her nitro and her turning up her O2 she uses for her hypoxemic chronic respiratory failure. She then called the rescues squad due to what she describes as unrelenting chest pain, like someone is stabbing her in the chest. In the ED patient received IV morphine, IV nitro and 5 liters O2 as her saturations were dropping to 87% on her usual 2 liters, she responded well to the 5 liters with O 2 saturations at around 93% which is her baseline on 2 liters. She reports associated cough for the past week beyond her usual from chronic bronchitis, her chest X-ray in the ED showed a possibility of a left lower infiltrate compared to her chest X-ray from a week ago in the ED.

Right now, patient states her chest pain still feels like continuous stabbing, rates it 8 out of 10, steady with some shortness of breath and feeling cold with chills. Given her previous history of CAD with previous MIs with CABG X 2, known inoperable lesion in the LAD, risk factors for another MI with diabetes, woman over 65 with past MI and general disconnect for following medical management and diet regimen, a decision to hospitalize the patient and rule out a MI with all the noted risk factors is prudent. Of note is that her cardiac enzymes are mildly elevated including her two troponins in the ED so we will cycle these as part of the workup.

What is The Physical Exam

The extent of the physical exam should incorporate the physician's clinical judgment and account for the patient's expressed and recorded nature of presenting problem. The physical exam findings should correlate with the patient's chief complaint and HPI; often there is a distinct disconnect between what is recorded in the HPI and the physical findings, such as describing a patient with extreme respiratory distress while under the constitutional part of the physical exam recording that the patient appears to be in alert, oriented x 3 and in no respiratory distress

Examples of the Physical Exam

Example #1:

History of Present Illness:

Mrs. Jones, a seventy-six-year-old female patient well known to me, presented to the ED today at 4 PM with extreme shortness of breath, she describes as gasping of air, almost choking in an attempt to breath. She was transported to the ED without incident and put on 100% nonrebreather O2 to manage her significant hypoxemia with acute on chronic respiratory failure with respiratory rate in the ED as high as forty with obvious respiratory distress. Decision to hospitalize the patient with acute on chronic respiratory failure with COPD patient with end stage GOLD stage IV COPD still smoking with 100 pack year history of smoking.

Physical Exam

Constitutional: Alert & oriented X 3 resting comfortably in bed in no apparent distress

Respiratory: Unlabored breathing, chest congestion with obvious rhonchi and wheezes.

Assessment:

1. Acute on chronic hypoxemic respiratory failure
2. Acute exacerbation of COPD

Example #2:

(a better Physical Exam with one small but very important change)

History of Present Illness:

(same as above in Example #1)

Physical Exam

Constitutional: Alert & oriented X 3 resting comfortably in bed in no apparent distress **with patient on 5 liters high flow O2**

Respiratory: Unlabored breathing, chest congestion with obvious rhonchi and wheezes.

Assessment:

1. Acute on chronic hypoxemic respiratory failure
2. Acute exacerbation of COPD

What is The Assessment

An assessment should contain definitive diagnoses expressed with clinical specificity of acute conditions (i.e., acute systolic CHF versus CHF), stability of chronic conditions (i.e., chronic stable acute systolic CHF, chronic kidney disease, stage IV)

Examples of the Assessment

Example #1:

(insufficient)

Assessment

1. Chest pain rule out MI
2. Hyperlipidemia
3. Type II diabetes
4. Morbid obesity
5. History of COPD
6. History of pulmonary embolism
7. History of MI
8. History of colon cancer s/p hemicolectomy
9. History of breast cancer s/p mastectomy
10. History of Atrial Fibrillation
11. History of Hypertension

Example #2:

(Sufficient)

Assessment

1. Chest Pain; Differentials include
    1. Type I MI in patient with numerous risk factors including previous MI, female patient over 65, morbid obesity, known CVADS with stent X 2 and CABG x 1 with known inoperable lesion in RCA, morbid obesity, sedentary lifestyle, 100 pack year of smoking with end stage COPD and diabetes Type II not well controlled due to medication noncompliance and dietary discretion.
    2. Pulmonary embolism-patient is at high risk for pulmonary embolism with previous pulmonary embolism, morbid obesity, on oral contraceptive pills, ongoing smoking and of note patient recently flew across country from Los Angeles to New York on an extended nonstop flight. Of note is her signs and symptoms of chest pain and shortness of breath are out of proportion to her physical exam.

What are The Comorbidities

Inclusion of comorbid clinical conditions that increase the complexity of management in the patient encounter documented in the assessment with appropriate clinical specificity

Inclusion of all relevant comorbidities that impact the complexity in management of the acute condition(s) that occasioned the admission to the hospital ion the assessment cannot be overemphasized. Comorbidities impacting the management of the acute condition(s) play directly into the amount and complexity of the physician's clinical judgment and medical decision making deployed and called upon for overall patient management. These same comorbid conditons help capture and depict the true clinical picture of the patient's clinical story and establishment of medical encessity for hospital level of care and the medical encessity for the physician's work performed and subsequent Evaluation and Management service coded and billed to the payer.

Examples of The Comorbidities

Example #1:

(Insufficient documentation)

1. Acute on chronic systolic congestive heart failure- patient ate a large Turkey dinner as part of Thanksgiving; dietary indiscretion that always leads to acute exacerbation of heart failure in this patient
2. Hypertension-
3. Hyperlipidemia
4. Obesity
5. Asthma
6. Osteoporosis

Example #2:

(Sufficient documentation)

1. Acute on chronic systolic congestive heart failure- patient ate a large Turkey dinner as part of Thanksgiving; dietary indiscretion that always leads to acute exacerbation of heart failure in this patient
2. Chronic Renal Failure stage IV, will have to judiciously dry out the patient with diuretic given the tendency of the patient to go into acute renal failure with exacerbation of CHF, will consult pharmacy for recommendation of type and renal dosing of diuretic

What is The Analytical Assessment Process

Documentation in the record should explicitly reflect the analytical assessment process involved in **medical decision making.**

This is what is referred to as clinical judgment & medical decision making. See the assessments above for examples of sufficient and insufficient assessments.

Clinical judgment is defined as the assessment by the physician of the patient's particular clinical scenario and the initiation of action congruent with the assessment

Medical decision making is defined the challenges and complexity of arriving at a diagnosis or diagnoses and/or selection of a management action plan for the patient

The physician's clinical judgment & medical decision making must incorporate elements of medical necessity as defined by the following:

- Number, acuity, severity, and duration of problems the physician must contend with and address
- Previous treatment and management of the patient's clinical condition that they present with
- Extent to which comorbidities increase the complexity in working up and managing the patient's acute problems or conditions that the patient presented with
- Extent of the physician exam performed to address patient's clinical signs/symptoms and presentation.

Examples of Analytical Assessment

See the Examples of Assessments above for examples of sufficient and insufficient assessments.

And here's one more example...

Example #1:

(Sufficient documentation)

Clinical Impression

1. Acute on chronic left side systolic heart failure complicated by right heart failure second to chronic cor pulmonale
2. Chronic kidney disease stage IV secondary to long standing diabetes and hypertension that were both not well controlled. Will consult pharmacy to seek guidance on type of diuretic and renal dosing to use in this challenging clinical situation with patient with CKD stage IV having a tendency to go into acute renal failure with too much diuretic. Must be judicious in drying out the patient without driving patient into acute renal failure. I have experience with this patient during his previous admission for acute on chronic heart failure

What is The Assessment

An assessment should contain documentation of any and all clinically relevant, pertinent differential diagnoses, diagnostic considerations and provisional diagnoses that will be entertained in the workup of presenting signs and symptoms, A typical example is chest pain and shortness of breath, diagnostic considerations, 1) NSTE MI in a patient with risk factors of family history of MI and early death,) Pulmonary embolism in a patient with previous PE and sub therapeutic INR noncompliant, and 3) New diagnosis of acute CHF in a patient with risk factors of hypertension and coronary artery disease.

An assessment should contain definitive diagnoses expressed with clinical specificity of acute conditions (i.e., acute systolic CHF versus CHF), stability of chronic conditions (i.e., chronic stable acute systolic CHF, chronic kidney disease, stage IV).

See the Examples of Assessments above.

What is The Statement of Complexity & Clinical Judgement

Clear and complete capture and reflection of the physician's clinical judgment and complexity of the case as a matter of principle and establishment of medical necessity in the assessment and plan of care.

See the Examples of Assessments above.

What is The Two Midnight Rule Expectation

"The patient's clinical indicators as documented and reported in the record, physician documentation of patient's sign and symptom, severity of signs and symptoms, medical predictability of an adverse event, detailed assessment including definitive and provisional diagnoses, and plan of care congruent and reasonable with the assessment are integral to the support of the physician's determination of need for inpatient level of care. The reasonableness of the physician's expectation that the patient will require care that spans at least two midnights supported by his/her documentation is the driving force in the application of the two-midnight rule. "

The following summarizes CMS's expectation of the physician adhering to sound principles of documentation and communication of patient care:

- QIOs will continue to follow longstanding guidance to review the reasonableness of the inpatient admission for purposes of Part A payment based on the information known to the physician at the time of admission. The expectation for sufficient documentation is well rooted in good medical practice "supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities," according to § 1156 of the Social Security Act.

- Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. QIOs will expect such factors to be documented in the physician assessment and plan of care. The entire medical record may be reviewed to support or refute the reasonableness of the physician's expectation, but entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission.

The underlying premise for physicians and CDI professionals alike is to realize that documentation accuracy and completeness representing what the physician clinically knew and recognized at the time of decision to hospitalize the patient is paramount to adhering to the two-midnight rule. What the physician knew at time of decision to hospitalize the patient is rooted in taking and recording an accurate well told History of Present Illness, performing and recording of a physical exam congruent with the nature of presenting problem and physician's clinical judgment, recording observations and findings and clinical significance of all diagnostic test results, and lastly tying everything together with an assessment and plan of care representative of the patient workup and clinical thoughts of the physician. This includes an assessment with definitive and/or provisional diagnoses with appropriate clinical specificity as well as inclusion of comorbid conditions impacting the physician's clinical judgment and medical decision making. Even more important is the inclusion within the documentation of the physician's clinical thoughts, clinical rationale and clinical criteria used in arriving at the diagnosis(es) recorded.

Examples of Insufficient Documentation for the 2MN Rule Expectation

Example #1:

(Insufficient)

Assessment

1. Chest pain, Rule Out MI
2. Hypertension
3. Atrial fibrillation
4. Diabetes Type II
5. Obesity
6. History of colon cancer, s/p colectomy
7. History of stroke

Patient with well-known risk factors for MI including previous MI, s/p CABG x 2, CAD with PTCA with one inoperable lesion, female patient over 65 with strong family history of CAD with premature death, diabetes, and sedentary lifestyle, presented to the ED last night with excruciating chest pain of two days duration that occurred at 8 PM that persisted despite taking her angina meds. She had similar presentation of chest pain last week and was discharged from the ED with a diagnosis of gastroenteritis with anxiety from stress related to recent death of husband. An evolving MI with mildly elevated troponins and continued chest pain in ED after Nitro, Morphine and Oxygen 4 liters requires close monitoring and workup in the hospital is a reasonable need for inpatient level of care.

Example #2:

(Sufficient)

Assessment

1. Chest pain-Differentials are:
    1. Evolving MI
    2. Stress related chest pain
    3. Anxiety induced chest pain
2. Diabetes Type II
3. Atrial fibrillation
4. Obesity
5. Sedentary lifestyle
6. Known CAD s/p CABG and PTCA
7. Previous MI
8. Strong Family History MI

(Remainder as above in Example #1)

A Call to Action

I am issuing a call to action to all CDI professionals, to recognize the immediate need for transformation in current CDI practices that are ill prepared and not designed to improve physician clinical documentation. CDI software billed as the panacea for documentation improvement must be thought of and treated as a tool, not vs a crutch.

It is incumbent upon each and every CDI professional to step up to the plate and acquire the skill sets, knowledgebase, and core competencies to become a driving force in a movement to achieve excellence in documentation integrity. Such excellence will certainly both improve and secure reimbursements for current and future years.

Current CDI certifications demonstrate the attainment of the minimum standards for CDI professional; there is far more to learn and attain as a CDI professional to continue career growth and created value to our organization as well as our individual lives. We must have a strong sense of duty to our hospital employers to alleviate the severe financial drain imposed by unnecessary avoidable denials, especially with the significant operational financial challenges faced with the COVID pandemic.

Furthermore, I call on ALL revenue cycle professionals to commit to driving down and alleviating denials first and foremost by embracing a proactive preemptive approach to documentation integrity.

It should be clear to any objective observer that present day CDI processes are ill prepared to avoid denials in the first place; in many ways CDI activity consisting of the query process is provably contributing to denials.

That is definitely not a healthy position to be in, no matter how you look at it, for your hospital, for the jobs of you and your colleagues, and for your patients and community.

My thanks to all for reading all this and for taking it to heart!

As my friend and colleague Ernie de los Santos often says, "You are all HEROES!"

And I hope I've been able to help you in your battles to make Payer auditors "bug out" because you're so good a documenting medical necessity in the appropriate way!

Best Wishes,

Glenn Krauss
BBA, RHIA, CCS, CCS-P, CPUR, CCDS, C-CDI, C-DAM
Founder and Creator of **Core-CDI.com**
Co-Founder and CDI Coach at **TopGun Audit School**
Glenn.Krauss@Core-CDI.com
(603) 303-3337

Make Payer Auditors "Bug Out!" When They See Your Excellence

Nationally known speaker, author and CDI Evangelist Glenn Krauss teaches the Eight Key Ingredients needed to LOCK ON to Medical Necessity, encouraging Payor Auditors to leave you alone and stop sending you ridiculous audits, even for all those Short Stays!