Medical Necessity-It's a Physician Thing

CORE CDI

Medical necessity is a concept not only relevant to the hospital. All services ordered and/or provided by physicians with certain exceptions must meet provisions of medical necessity, regardless of third party payer.

- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of an E & M CPT code. Emphasis should be on accurate, clear, concise and succinct documentation of the patient encounter, not volume of documentation but simply more effective documentation. (Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.B)

Documenting Accurately & Completely, Reflective of the Patient Encounter & Demonstration of Medical necessity

- Clearly document the services rendered for the patient needs at the time of the encounter. Key is a clear depiction showing and describing the patient's clinical condition including chief complaint and an encompassing History of Present Illness, focusing only upon "the present illness" and past clinical conditions relevant to the reason for the encounter as included in the HPI and Chief Complaint, i.e., past history of MI and family history of MI in a patient who presents with chest pain and shortness of breath. Other relevant diagnoses can be listed in the Past Family Social History

- Outline and document your work performed-cognitive and physical, additional services rendered and the reason(s) for those services

- Perform and document a clear picture of the patient's clinical condition(s) and treatment in your assessment and plan of care:

    - What are your thinking- definitive and/or provisional diagnosis(es);
    - Why are you thinking- clinical judgment, medical decision making, clinical criteria, thought processes and analytical skills;
    - Where are you going- diagnostic/therapeutic workup and treatment, carefully linking each to the definitive or provisional diagnosis(es)

Reality vs. Myth

- You as a practicing physician control the establishment of medical necessity for E & M encounters, not the insurance company. Your documentation should be clear, concise in describing and showing the patient's story, clinical conditions, need for care, services rendered and the reason(s) for the work you performed.

- Your H & P and progress notes should clearly demonstrate, report and reflect the following:

    - Assessment of the patient's particular clinical scenario and initiation of action, plan and continuity of care and congruent with the assessment

    - Don't shortchange yourself by documenting nonspecific diagnosis(es) in your assessment-it is critical to document appropriate clinical acuity, acute, chronic, acute-on chronic and include relevant "history of" conditions, not confusing true history of versus chronic stable, i.e., history of COPD versus chronic stable CHF