Proving Medical Necessity, Functional Improvement, and Maintenance Care

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ICD-10

- Medicare is switching to ICD-10 on October 1.
- It is time to get ready if you haven't already.
- Dr. Evan Gwilliam and I will be presenting an ICD-10 and Medicare Documentation seminar at National College on September 19.
- To register for this seminar go to: http://events.r20.constantcontact.com/register/event?oeidk=a07eap35gib8b94bf9c&llr=e9rlipdab

The Big Three

- The three major complaints that Medicare has regarding chiropractic according to the 2009 OIG Report.
- We do not properly document medical necessity
- We do not document appropriate treatment plans
- We do not properly document maintenance therapy
- We are going to discuss these two.
    - We do not properly document medical necessity
    - We do not properly document maintenance therapy

Proving Medical Necessity

- The primary reason that Medicare denies a claim is because the documentation does not prove medical necessity.
- How does Medicare define "Medical Necessity"?
- How do you prove "Medical Necessity"?
- Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3
    - "The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function."
- What is the definition of a "significant health problem" in the context of functional improvement?
    - The following applies to the Revised Oswestry Low Back Pain Disability Questionnaire.
    - According to Dr. Yeomans' book *The Clinical Application of Outcomes Assessments*, "…a score of 11% may be used as an appropriate cut-off score … to consider for discharge and/or return to work in an uncomplicated low back pain case."
    - Therefore, any impairment of greater than 11% could be considered a significant problem.
- Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3

    - Acute subluxation-A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of, the patient's condition.
- Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3
    - Chronic subluxation-A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.
- Medically Necessary care must provide either recovery or improvement of function.
- For acute cases, the care must provide significant improvement.
- For chronic cases, the care must provide some improvement.
- How do you document improvement of function?
- Outcome assessment questionnaires.
- How do you document recovery?
- Outcome assessment questionnaires.

Outcome Assessment Questionnaires

- "Questionnaires designed to measure a patient's limitations in performing the usual human tasks of living. Functional questionnaires seek to quantify symptoms, function and behavior directly, rather than to infer them from less relevant physiological tests."
- Examples of outcomes assessment questionnaires.
    - Roland-Morris Questionnaire
    - Revised Oswestry Low Back Pain Disability Questionnaire
    - Neck Disability Questionnaire
    - Other specialized questionnaires as indicated
    - Headache Disability Index
    - Dizziness Handicap Inventory
    - Shoulder Evaluation Form
    - Carpal Tunnel Questionnaire
    - Tinnitus Handicap Inventory
- Outcome Assessment Questionnaires should be administered at the initial exam and at each re-exam.
- How often should that be?
- Every 30 days.
- Why?
- Because Medicare considers an Outcome Assessment Questionnaire to be current if it is 30 days or less old.

- When using Outcome Assessment Questionnaires to demonstrate functional improvement, you must have significant improvement between adjacent questionnaires for an acute case.
- Significant improvement is defined as 30% improvement.

Maintenance Therapy

- We see that Medicare wants functional improvement or recovery to prove Medical Necessity.
- What do they want for maintenance therapy?
- Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3(A).
    - "Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy."
- When the patient reaches Maximum Medical Improvement, they should be placed on maintenance care.
- MMI is determined by use of the outcome assessment questionnaires.
- In an acute case, when there is no significant improvement (30% or more) between two exams 30 days apart, the patient is at MMI.
- In a chronic case, when there is no improvement between two exams 30 days apart, the patient is at MMI.
- Example:
    - At the initial exam the patient was 50% impaired.
    - At the first re-exam the patient was at 30% impairment.
    - This is a 40% improvement.
    - It is above 30%.
    - Keep going!
    - At the next re-exam the patient is at 20% impairment.
    - This is a 33% improvement.
    - It is above 30%.
    - Keep going!
    - At the next re-exam the patient is at 15% impairment.
    - That is 25% improvement.
    - It is below 30%.
    - The patient has now reached MMI.
- Maintenance therapy is reported to Medicare by discontinuing the use of the AT modifier.
- Without the AT modifier appended to a CPT code for CMT, Medicare will identify the claim as maintenance care and will deny the claim as not medically necessary.
- Once Medicare has denied the claim and assuming that you have properly utilized the ABN to inform the patient of their financial liability, future adjustment are considered non-covered services by Medicare and can be treated as such.

- An ABN notifies the beneficiary that Medicare is likely to deny the claim and that if Medicare does deny the claim, the beneficiary will be liable for the full cost of the services.
- Medicare Claims Processing Manual, Chapter 30, Section 50.13.
    - "Regardless of whether they accept assignment or not, providers and suppliers are permitted to charge and collect the usual and customary fees; therefore, funds collected are not limited to the Medicare allowed amounts."

Acute Case Protocol

- At the initial assessment visit, the patient is administered appropriate outcomes assessment questionnaire(s) to establish their baseline impairment.
- The impairment recorded should be greater than 11%.
- The patient is then treated according to the treatment plan developed.
- During the next assessment visit 30 days later (the re-exam) another outcomes assessment questionnaire(s) is administered.
- If there is 30% improvement then there is significant functional improvement and the care can be considered medically necessary and, if the current impairment is greater than 11%, another 30 days of care may be indicated.
- If there is improvement, but not 30% improvement or the current impairment is 11% or less, the patient is at MMI.
- If there is improvement, but not 30% improvement and the current impairment is greater than 11%, the patient is at MMI with residual impairment.
- If there is little or no improvement, the patient is unresponsive and you should consider referring the patient.

Chronic Case Protocol

- At the initial assessment visit, the patient is administered appropriate outcomes assessment questionnaire(s) to establish their baseline impairment.
- The impairment recorded should be greater than 11%.
- The patient is then treated according to the treatment plan developed.
- During the next assessment visit 30 days later (the re-exam) another outcomes assessment questionnaire(s) is administered.
- If there is improvement and the current impairment is greater than 11% then the care can be considered medically necessary.
- If there is no improvement and/or the current impairment is less than 11%, the patient can be considered to be at MMI.

Summary

- Medicare must, by law, pay claims that are medically necessary.

- Medicare's definition of medical necessity is recovery or improvement of function.
- When functional improvement is no longer expected then the patient is placed on maintenance care.