THINK IN INK

This month, we'd like to provide some clarity about an often-talked about, but seldom understood term—medical necessity. Medical necessity is the clinical justification for the medical treatment you provide to your patients. The reason the term has become so popular is that "medical necessity" is the concept insurers and governmental payors are emphasizing to deny charges and reduce reimbursement. Here's how it works: payors in the audit setting are claiming that the physician's work-up was unjustified in light of the patient's final clinical impression. In other words, they are arguing that the orders and tests were not "medically necessary" and consequently, should not be considered in determining the medical decision-making in the case. When successful, this argument reduces in the E&M level (and reimbursement amount) assigned to the case.

Clearly, this common denial strategy ignores the complex medical decision-making physicians perform when attempting to rule out potential diagnoses. However, if there's no evidence of the decision making in the patient record, it's difficult for us to make the case to an unsympathetic payor that the decision making actually occurred. So, this month, our documentation tip is designed to help defend your documentation from medical necessity attacks. We're boiling it down to just one tip, so remember it: "Think in Ink by Documenting Differential Diagnoses".

What we mean by this is that if you order tests to rule out a potential diagnoses, include those possible diagnoses in the record. This will justify the necessity of these orders and make it difficult for auditors to downplay the treatment interventions and work-ups you order. On the flip side, don't include potential diagnoses that you do not treat or "work-up" as this can lead to a significant risk of medico-legal exposure. Here's an example of what we're talking about:

A 50-year old female presents to the ED with two-day old abdominal pain growing increasingly intense and a history of fever presenting at 101. An exam shows the patient's abdomen to be soft, with a normal appearance. Her bowel sounds are normal with no distension. There is tenderness in the LLQ. The physician orders a urinalysis and a CT of abdomen. The final diagnosis is UTI. In this case, the physician considered diverticulitis, appendicitis with Rovsing's sign and pyleonephritis. However, if the physician doesn't mention these possibilities in the record, a payor auditing the chart is not going to consider them. This opens the door for the payor to try and down code the claim's coding assignment of a Level 5 to a Level 4. The best way to defend your charts from this kind of attack is through documenting the differential diagnoses. In this case, noting that diverticulitis, appendicitis with Rovsing's sign and pyelonephritis were possible, but not present, the physician would have supported the medical complexity of the case, the need for the CT and ultimately, the E/M code (and corresponding reimbursement amount) assigned to the case.

You work hard to care for your patients. Don't let a second-guessing payor dock your payment because you failed to jot down the differential diagnoses you considered. "Thinking in Ink" like this with bolster the defensibility of your claims, and ensure that you receive the full amount of reimbursement you have earned.