Proving Medical Necessity and Functional Improvement

Revalidation

- Revalidation is continuing.
- Last month I stated that there may be fees involved this time.
- CMS has clarified their position.
- There are no fees for physicians to revalidate.
- There have been reports of scammers posing as local MACs trying to get doctors to forward revalidation fees to them.
- Revalidation will occur from now to March 23, 2015.
- It is advisable to use the PECOS system to revalidate.
- PECOS is faster than paper applications.
- Remember, you have 60 days from the postmark on the notification envelope to submit your revalidation.

Sequestration

- Sequestration has gone into effect as of April 1, 2013, resulting in a 2% cut to Medicare fees.
- The Sequestration Fee Cut will be reflected as a 2% cut in your fees.
- This cut applies to all claims with a date of service on or after April 1, 2013.
- The cut will be indicated on the Electronic Remittance Advice or the Standard Paper Remittance with the Claim Adjustment Reason Code (CARC) of 223.
- The stated reason for the CARC is "Adjustment code for mandated Federal, State or local law/regulation that is not already covered by another code and is mandated before a new code can be created."
- This adjustment will be reported on each line of the remittance advice.
- For assigned claims and par providers the reduction is taken from the calculated payment amount, after the approved amount is determined and the deductible and coinsurance are applied.
- Example: A provider bills a service with an approved amount of $100.00, and $50.00 is applied to the deductible. A balance of $50.00 remains. We normally would pay 80% of the approved amount after the deductible is met, which is $40.00 ($50.00 x 80% = $40.00). The patient is responsible for the remaining 20% coinsurance amount of $10.00 ($50.00 - $40.00 = $10.00). However, due to the sequestration reduction, 2% of the $40.00 calculated payment amount is not paid, resulting in a payment of $39.20 instead of $40.00 ($40.00 x 2% = $0.80).
- For non-par providers and unassigned claims Medicare's payment to beneficiaries for unassigned claims is subject to the 2% reduction. The non-participating physician who bills on an unassigned basis collects his/her full payment from the beneficiary, and Medicare reimburses the beneficiary the Medicare portion.

- This reimbursed amount to the beneficiary would be subject to the 2% sequester reduction just like payments to physicians on assigned claims.
- Example: A non-participating provider bills an unassigned claim for a service with a Limiting Charge of $109.25. The beneficiary remains responsible to the provider for this full amount. However, sequestration affects how much Medicare reimburses the beneficiary. The non-participating fee schedule approved amount is $95.00, and $50.00 is applied to the deductible. A balance of $45.00 remains. Medicare normally would reimburse the beneficiary for 80% of the approved amount after the deductible is met, which is $36.00 ($45.00 x 80% = $36.00). However, due to the sequestration reduction, 2% of the $36.00 calculated payment amount is not paid to the beneficiary, resulting in a payment of $35.28 instead of $36.00 ($36.00 x 2% = $0.72).
- Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.
- All fee schedules, Pricers, etc., are unchanged by sequestration; it's only the final payment amount that is reduced.

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"?
- The quote below is from the 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."
- Medically Necessary care must provide either recovery or improvement of function.
- How do you document improvement of function?
- You utilize 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."

Which Outcome Assessment Questionnaires do you use?

- Roland-Morris Questionnaire
- Revised Oswestry Low Back Pain Disability Questionnaire
- Neck Disability Questionnaire
- Other specialized questionnaires as indicated

Where do you find information on Outcome Assessment Questionnaires?
You can information in Dr. Steven Yeomans book *The Clinical Application of Outcomes Assessment*. I recommend that you also buy the companion forms CD.

W**hat additional Outcome Assessment forms could you use?**

- Headache Disability Index
- Dizziness Handicap Inventory
- Shoulder Evaluation Form
- Carpal Tunnel Questionnaire
- Tinnitus Handicap Inventory

When do you use Outcome Assessment Questionnaires?

- 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.
- Significant improvement is defined as 30% improvement.

Maintenance Care

- We see that Medicare wants functional improvement 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.
- When there is no significant improvement (30% or more) between two exams, 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 greater than 30%, keep going!At the next re-exam the patient is at 20% impairment.
- This is a 33% improvement.

- It is greater than 30%, keep going!At the next re-exam the patient is at 15% impairment.
- That is 25% improvement.
- This is less than 30%, the patient has now reached MMI.

How do you report Maintenance Therapy to Medicare?

- 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 necessaryOnce 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 Benefits Policy Manual, Chapter 15, Section 40.
- "Where a valid ABN is given, subsequent denial of the claim relieves the non-opt-out physician/practitioner, or other supplier, of the limitations on charges that would apply if the services were covered."

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.Outcome Assessment Questionnaires are very effective at determining functional improvement and MMI.
- It is the responsibility of you, the doctor, to document your services and prove medical necessity.