

Proving Medical Necessity and Functional Improvement

- 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 find information in Dr. Steven Yeomans book *The Clinical Application of Outcomes Assessment*. I recommend that you also buy the companion forms CD.

What 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 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 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.