Proving Medical Necessity 2023

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What is Medical Necessity

- It is important to understand the difference between Medically Necessary care and Clinically Indicated Care.
- Medical necessity is a legal term used by third party payers to indicate care for which they will be contractually liable and will pay.
- This term is used in the Social Security Act to indicate the care that Medicare is required by law to cover and pay for.
- If you expect a third-party payer to pay for the care that you are rendering then you need to prove the medical necessity of the care provided.
- Clinically indicated care is the care that you determine is correct and proper for the patient given their condition.
- It may not be considered medically necessary by a third-party payer.
- Clinically indicated care can include maintenance care in order to prevent or delay the recurrence of a problem.
- Always remember that you are the doctor and that the patient is coming to you with their problem.
- It is your job to use your training, your knowledge, and your experience to determine what is wrong with the patient, and what the proper course of care is for that patient.
- Your recommendation should not be based on how much the care will cost or who will be paying.
- You make the recommendation that the patient needs.
- It is up to the patient to determine what they are able to do and how well they can follow your recommendation.

Documentation Standards

- There are three sources of guidelines that we can reference to develop our documentation for the chiropractic office;
- National Committee for Quality Assurance (NCQA) Guidelines for Medical Record Documentation,
- Centers for Medicare and Medicaid Services (CMS) Evaluation and Management Documentation Guidelines,
- Medicare Benefits Policy Manual, Chapter 15, Section 240.1.2.
- The Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3 states:
    - 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. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, as described above.
- Now let's underline the key elements:

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    - 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. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, as described above.
- A little more clarity can be obtained by referencing Section 1862 (a)(1)(a) of the Social Security Act which states: (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
- (1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- When we put all of this together, we find that the first requirement of proving medical necessity is that the patient must have a significant health problem in the form of a neuromusculoskeletal condition that results from illness, injury, or a malformed body member that necessitates treatment.
- The next requirement is that the adjustment given must have a direct relationship to the condition and provide an expectation of recovery or improvement of function.
- The next sentence states; "The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, as described above."
- So, let's put this information together and lay out some questions that need to be answered in the documentation to prove the medical necessity of the care.
    - Does the patient have a significant health problem?
    - Is the problem a musculoskeletal condition?
    - Did the condition result from illness, injury, or a malformed body member?
    - Is the adjustment expected to help this condition?
    - Did you prove the presence of a subluxation either by the use of x-rays or the P.A.R.T. examination?
    - Did the patient benefit from the adjustment?
- Question 1 is answered in both the history and the examination portions of the documentation.
- Questions 2 and 3 are answered in the history portion of the documentation.
- Question 4 is the doctor's opinion and is answered in the assessment portion of the documentation.
- Question 5 is answered in the objective portion of the documentation.
- Question 6 is answered in the objective and assessment portions of the documentation.

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- Taking a good chief complaint (CC) and history of present illness (HPI) will provide you with the information that you need to answer questions 2 and 3 and partially answer question 1.
- Conducting the appropriate exams to determine the presence of subluxation(s) will answer question 5.
- For Medicare patients you should use either x-ray of P.A.R.T. to determine the presence of subluxation(s).

- Question 4 is answered by you placing a notation regarding your opinion as to whether the patient will be helped by the adjustment in the assessment portion of the documentation.
- This leaves part of question 1 “Does the patient have a significant health problem?” and question 6 “Did the patient benefit from the adjustment?”.
- These two questions are answered by utilizing exams that measure the patient’s initial functional impairment and functional improvement as the case progresses.
- Some have suggested that this can be accomplished by quantifying and placing a numeric value on the results of the orthopedic and neurological exams.
- While that may provide some small benefit it is not the designed purpose of the ortho/neuro exams.
- They were designed to determine the presence or absence of pathological processes.
- There are three exams that lend themselves to identifying and quantifying the patient’s impairment and subsequent improvement;
    - Range of motion exams
    - Muscle strength exams
    - Outcome assessment questionnaires

Range of Motion Testing

- Range of motion can be measured in a variety of ways ranging from visualization (just looking at the patient performing the test and estimating the degree of movement) to dual digital inclinometry which is the gold standard of range of motion testing according to the AMA Guides to the Evaluation of Permanent Impairment.
- The more accurate the testing method the more you are able to use the test as a measure of functional improvement.

Muscle Strength Testing

- Muscle strength can be tested by using a dynamometer or by using a grading scale originally developed by the Medical Research Council of the United Kingdom that is now universally used.
    - 0: No visible muscle contraction
    - 1: Visible muscle contraction with no or trace movement
    - 2: Limb movement, but not against gravity
    - 3: Movement against gravity but not resistance
    - 4: Movement against at least some resistance supplied by the examiner
    - 5: Full strength
- The problem with this scale if that there is a large range of strength possible between grades 4 and 5.
- Conversely a dynamometer will provide results in pounds of resistance and it will be much easier to calculate percentage of impairment and percentage of improvement.
- As with range of motion testing the more accurate the method you use the better able you are to use the results to demonstrate functional improvement.

Outcome Assessment Questionnaires

- Outcomes Assessment Questionnaires, now more commonly called Outcomes Assessment Tests or OATS for short, are the standard within the medical profession for measuring the functional impairment of patients.
- Medicare also regards these questionnaires as an acceptable measure of the patient's functional impairment.
- The most commonly used outcome assessment questionnaires in the chiropractic profession are the Neck Disability Index and the Revised Oswestry Low Back Pain Disability Questionnaire.
- According to The Clinical Application of Outcomes Assessments by Dr. Steven Yeoman's a score of 11% is the minimum threshold indicating a significant functional impairment.
- Significant improvement is defined as a 30% improvement between adjacent questionnaires 30 days apart.
- When you no longer have 30% improvement on an acute case, it is a strong indication that the patient has reached Maximum Medical Improvement.
- Chronic cases may have a little more latitude depending upon the other objective indicators.

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- The outcome assessment questionnaire should be your primary tool for measuring functional impairment because it is the most effective.
- It is also the one that reviewers specifically look for.
- Range of motion and muscle strength testing will serve to reinforce the results of the outcome assessment questionnaire.
- When used during the initial assessment/evaluation visit these tools will determine if the problem is significant.
- When used during the re-exam the results can be compared to those of the previous exam to determine functional improvement.
- Documented functional improvement is proof that the patient benefited from the adjustment.
- Re-exams should occur every 30 days or as soon as possible thereafter because outcome assessment questionnaires are designed to be administered every 30 days and are only current within that 30-day period.
- It would follow that any care rendered more than 30 days after the administration of an outcome assessment questionnaire would have no justification and would not meet the requirement for medical necessity.
- To state it another way, as long as there is a current outcome assessment questionnaire in place that indicates significant functional impairment and that significant functional improvement is proven, then the care is most likely medically necessary.
- If there is no functional assessment then there is nothing to indicate that the patient has a significant functional impairment.

Summary

- Third party payers will pay claims when those claims are proven to be medically necessary.
- The only published standard for chiropractic states that medical necessity is tied to functional impairment and functional improvement.
- Using the proper tools in the proper way will prove functional impairment and functional improvement as the care progresses.