PINNACOL ASSURANCE

Medical Necessity and Overarching Criterion

For any medical service to be reimbursed, medical necessity is the overarching criterion for payment. The Centers for Medicare and Medicaid Services address overarching criterion when selecting Evaluation and Management (E&M) codes this way: “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level of service is warranted.”

The volume of documentation should not be the basis for the level of service billed. A potential unintended consequence of electronic medical records is that documentation may be auto populated that is not medically necessary or appropriate for the presenting condition.

Medical necessity: Activities justified as reasonable, necessary and/or appropriate based on evidence-based clinical standards of care.

Overarching: Affecting or including everything, and therefore very important, essential and fundamental.

Following are examples of frequent injuries sustained by injured workers (IW) and how medical necessity affects the documentation and code selection:

Documentation Example 1: *IW presents with new injury of left knee. Stepped onto a rock and twisted knee. Immediate pain and swelling in medial knee, feels unstable. An x-ray was ordered, reviewed, and confirmed no fractures. Recommend ice, OTC ibuprofen, and PT.*

Comment: IW presents with one self-limited or minor problem, no risk factors, over the counter ibuprofen and physical therapy ordered. No comprehensive history or exam are needed as the area of injury is limited and no other body areas were affected.

Even if the provider chose to perform and document a comprehensive history and exam, 99204 or 99205 should not be billed because the medical decision-making (MDM) for this injury is of low complexity.

Documentation Example 2: *IW presents with a new injury - laceration to right thumb. Sliced thumb while using a knife to open a package. The wound cut into subcutaneous tissue, requiring a single layer closure and prophylactic antibiotics were ordered.*

Comment: Should the new patient visit be billed as 99204? MDM is of moderate complexity but 99204 includes a comprehensive history and exam. Is a comprehensive history and exam required for an injury isolated to the right thumb?

Billing 99204 or 99205 would not be appropriate. It is not medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.

According to the American Academy of Professional Coders, "The best way to stay compliant with medical necessity related laws is to think of each element of the patient's history and physical exam as a separate procedure that should be performed only if there is a clear medical reason to do so."

To justify the service billed, specific signs, symptoms or complaints are what make the services medically necessary or deemed as reasonable. When the review of systems and exam exceed the level of care reasonably needed for the presenting condition, payment for higher level services may be denied.

This document is not intended in any way to direct the type or duration of medical treatment that may be prescribed. Medical providers must exercise their independent medical judgment in these matters.

References

Centers for Medicare and Medicaid Services - Selection of level of E&M service
www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf

American Academy of Professional Coders - Medical necessity
www.aapc.com/blog/36436-medical-necessity-vs-mdm-we-have-a-winner/