Medical Necessity: What Is It?

Documenting to Support Medical Necessity: What CMS and Payors Need

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for

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Medical Necessity

- Definition
- Finding the Guidelines/Policies
- Documenting
- Appealing
- Teaching Your Providers

Wikipedia definition

- **Medical necessity** is a United States legal doctrine, related to activities which may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Other countries may have medical doctrines or legal rules covering broadly similar grounds. The term **clinical medical necessity** is also used.

About.com definition

- Health insurance companies provide coverage only for health-related serves that they define or determine to be medically necessary. Medicare, for example, defines *medically necessary* as: "Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice."
- Medical necessity refers to a decision by your health plan that your treatment, test, or procedure is necessary for your health or to treat a diagnosed medical problem.

Attorney definition

As explained to a client undergoing a Medicaid audit

- There is a difference between clinical medical necessity and billing medical necessity
- Just because YOU think it's medical necessary doesn't mean it's going to be

AMA Definition

Services or procedures that a prudent physician would provide to a patient in order to prevent, diagnose or treat an illness, injury or disease or the associated symptoms in a manner that is:

- In accordance with the generally accepted standard of medical practice.
- Clinically appropriate in terms of frequency, type, extent, site and duration.
- Not for the intended for the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider.

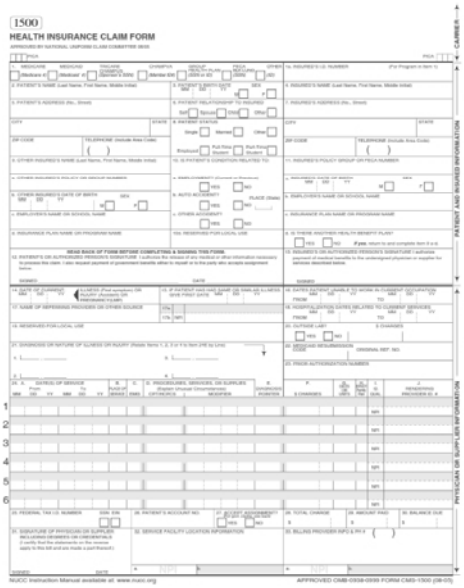
Medicare Definition

Medical necessity from a Medicare perspective is defined under Title XVIII of the Social Security Act, Section 1862 (a) (1) (a):

"No payment may be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Claim Form Language

Have you (or your doctors) ever read a CMS-1500 claim form?


1500

HEALTH INSURANCE CLAIM FORM

- Box 31 – Physician signature

"I certify that the statements made on the reverse apply to this bill and are made a part thereof."

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG):

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I nor any employee who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT):

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, Carrier Medicare Claims Record, published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in responses to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. The address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

"Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and me be subject to civil penalties."

"I certify that the services shown on this form were medically indicated and necessary for the health of the patient"

Diagnosis Coding

- Correct/appropriate/specific diagnosis coding is critical –
- But many diagnosis codes are not specific enough in themselves:
  - For example, one insurer has the following policy for Supartz
  - Failure of conservative treatment, i.e., physical therapy, weight loss, analgesic meds
  - Duration of 6 months or longer
  - X-ray confirmation of diagnosis (Grade II or III)
  - None of that information is conveyed by the diagnosis code
- ICD-10 will help – but it will not solve the problem

Finding the Information

- CMS – National Coverage Determination
- MAC – Local Coverage Determination
- Other Payers

- CPT "stays out of it" – does give scenarios in CPT Assistant and other publications but does not proscribe medical necessity

Medicare

http://www.cms.gov/medicare-coverage-database/

Can search for both National Coverage Determinations – NCDs as well as Local Coverage Determinations – LCDs

LCDs formerly known as LMRPs – Local Medical Review Policies

Other Payors

(Including Medicaid)

- May or may not have specific information available

Just because it is medically necessary in your physician's eyes does not mean it is a covered service!

Example: Visit before screening colonoscopy

Evaluation and Management

From the American Academy of Family Practice

Medical necessity of an E&M service is generally expressed in two ways: frequency of services and intensity of service (CPT level)

- Medicare's determination of medical necessity is separate from its determination that the E/M service was rendered as billed.
- Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.
- During an audit, Medicare will deny or adjust E/M services that, in its judgment, exceed the patient's documented needs

Evaluation and Management

Per CMS – Medicare Claims Processing Manual –

Medical necessity 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 evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

Evaluation and Management Nature of Presenting Problem (from the Table of Risk)

Nature of Presenting Problem	Level of Service	
	Office	Inpatient
Self-limited or minor problem	99201/99202 - 99212	
Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated illness or injury	99203 - 99213	99221 - 99231
One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	99204 - 99214	99222 - 99232
One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illness or injury that poses a threat to life or bodily function Abrupt change in neurologic status	99205 - 99215	99223 - 99233

Medical Necessity

Medical Necessity and Medical Decision-Making not the same thing

Clinical Descriptors

Most E&M code descriptions comment on the severity – a few elaborate further –

99231 "Usually, the patient is stable, recovering or improving."

99232 "…the patient is responding inadequately to therapy or has developed a minor complication."

99233 "Usually, the patient is unstable or has developed a significant complication or a significant new problem."

Balancing Medical Necessity and Meaningful Use

- Bringing forward medical history in an EMR is an important aspect of meaningful use
- Does this mean that you can count that comprehensive history toward the level of service for every office visit now and forevermore?

Breaking News!

Concerns with electronic records and overcoding

The Center for Public Integrity – September 2012

"coding levels may be accelerating in part because of increased use of electronic health records…."

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Sebelius-Holder Letter

September 24, 2012

To hospitals, but same principles apply –

"False documentation of patient care is not just bad patient care; it's illegal. The indications include potential 'cloning' of records in order to inflate what providers get paid."

http://www.nytimes.com/interactive/2012/09/25/business/25medicare-doc.html

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OIG Workplan for 2012

"We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported."

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What are the auditors looking for?

- Authentication – signatures, dates/times – who did what? (metadata?)
- Contradictions – between HPI and ROS, exam elements
- Wording or grammatical errors/anomalies
- Medically impausible documentation

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Medical Necessity?

Of services performed – or services billed?

Who is qualified to judge the medical necessity of a service?

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Congressional Response

October 4, 2012 letter to HHS Secretary Sebelius

"…your EHR incentive program appears to be doing more harm than good."

Request –

- Suspension of EHR bonus payments and delay penalties for providers who don't use EHR
- Increase what's expected of meaningful users
- Block business practices that prevent exchange of information

Certificate of Medical Necessity

Used for Durable Medical Equipment

- Often completed by DME provider and brought to physician for signature
- Physician is responsible for information submitted

How to Document Medical Necessity

- Tell a story
- Don't assume level of knowledge
- Don't rely on diagnosis documentation alone
- Review any payor medical policies – and document in their terms

  For example, for trigger point injections: "Patient reports 60% decrease in pain after previous injections"

How to Document

- Reason for any services ordered – labs, EKGs, Xrays, other diagnostic studies –

  CMS Documentation Guidelines:

  "If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred."

Who can judge?

- Debate among coding professionals/auditors as to whether they can judge medical necessity
- Quote from Alabama Medicaid: "All services must be reasonable and necessary in the specific case and must meet the criteria of specific governing policies. Medical record documentation must support coding utilized in claim and/or prior authorization submission.
- An outside auditor may judge your physician on medical necessity. Are you doing him/her a disservice by not reviewing this?

Appeal

- You can't assume that the payor will always follow their own policies
- Do other payors "allow" this diagnosis for the service?
- Is there additional information available in the chart that was not submitted with the original claim/audit? (Depending on payor policy, they may not have to consider it.)

Appeal Testimony

Helpful: Journal articles, patient success stories, other payer's favorable medical policies

Not Helpful (from actual physician testimony): "Let me come down there and rip open *your* belly and see if you think this second procedure was medically necessary."

NOTE: This physician did not prevail on appeal.

How to Teach Your Providers

Respectfully…

- You don't know what they know
- Give them a chance to tell you
- Suggest appropriate documentation in lay terms
- Remind them that someone who does not know this patient may ultimately be deciding whether what was done was appropriate

Advanced Beneficiary Notification

- Notifies a Medicare beneficiary that you have reason to believe that the services they are to receive today are not covered by Medicare – and asks the patient to agree to pay for the services

  "Advance Beneficiary Notices advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment for them. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket and to be more active participants in their own health care treatment decisions."

Advance Beneficiary Notices

Combined form – previously one form for laboratory and a separate form for general purposes

- May pre-print lab-specific information and denial reasons as noted on the previous ABN-L
- May also use in replacement of previous NEMB – Notice of Exclusion from Medicare Benefits

http://www.cms.gov/BNI

Estimated Cost

- Should be within $100 or 25% of the total
- If unable to give an estimated cost, must state that fact
- Routinely grouped services can be bundled into a single cost entry

Options

- **OPTION 1. I want the D. _____ listed above.** You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- **OPTION 2. I want the D. _____ listed above, but do not bill Medicare.** You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed
- **OPTION 3. I don't want the D. _____ listed above**. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Provider cannot pre-select the option!

ABN Rules

- Must be delivered before a procedure is initiated and before physical preparation of the patient begins
- Should be hand-delivered to patient or authorized representative
- Cannot be routine, generic, blanket
- Can be signed once per year for ongoing treatment

Modifiers for ABNs and NEMBs

GA – ABN on file

GY – service statutorily excluded or does not meet the definition of any Medicare benefit

GZ – service expected to be denied as not reasonable and necessary

Careful with use – these are on the OIG workplan for 2012

Affects the language on the patient's Medicare Summary Notice

MSN Language

Example

- The information provided does not support the need for this many services or items in this period of time but you do not have to pay this amount.
- You cannot be billed separately for this item or service. You do not have to pay this amount.

Hospital-Issued Notice of Noncoverage

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Is custodial in nature.

Hospital version of the ABN

Not Medically Necessary vs. Non-covered Services

Not medically necessary

- The patient does not have a diagnosis for which the service is normally covered
- The service is being provided more often than is approved
- May only bill the patient if ABN has been signed

Non-covered services

- Never, ever paid by Medicare
- May always bill the patient

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