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

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**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?
• Box 31 – Physician signature

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

<table>
<thead>
<tr>
<th>Nature of Presenting Problem</th>
<th>Level of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Office</strong></td>
</tr>
<tr>
<td>Self-limited or minor problem</td>
<td>99201/99202 - 99212</td>
</tr>
<tr>
<td>Two or more self-limited or minor problems</td>
<td>99203 - 99213</td>
</tr>
<tr>
<td>One stable chronic illness Acute uncomplicated illness or injury</td>
<td>99201/99202 - 99212</td>
</tr>
<tr>
<td>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</td>
<td>99204 - 99214</td>
</tr>
<tr>
<td>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</td>
<td>99205 - 99215</td>
</tr>
</tbody>
</table>
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...”
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.”


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.”
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 impossible documentation

Medical Necessity?

Of services performed – or services billed?

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