Best Practices for Medical Necessity Validation

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To protect the Medicare Trust Fund from being drained, government health plans must provide coverage restrictions for unnecessary health services in vulnerable patient populations. One restriction mechanism is the provision of edits that look for valid reason-for-visit codes for selected services. Staying current with these edits has been a challenge, particularly due to the increased complexity faced by hospitals for outpatient reporting using the prospective payment system.

Software is Only Half the Answer

Healthcare providers cannot rely solely on software applications to provide the appropriate information to substantiate medical necessity for tests and services ordered. Software programs only create an efficient way to manage LMRPs; they cannot substitute for sound HIM practices between the ordering physician and the health plan providing payment.

These applications provide organized feedback to providers based on whether or not a particular service (represented as a CPT code) will be covered by Medicare based on a match-up with an ICD-9-CM diagnosis code table. Most LMRPs contain examples of covered and non-covered ICD-9-CM codes, but there are many situations in which a service would meet medical necessity criteria based on text portions of policies that cannot be replicated in a table match-up. Further, there are some services that have such a wide variety of conditions that all possible codes are not listed. These services would be denied under certain circumstances—sometimes clearly indicated in the policy, sometimes not.

Complete blood counts (CBCs) are a common example of medical necessity denials. They are a common diagnostic tool that physicians use to evaluate a host of disease conditions and are a key indicator for ruling out an etiology. There are a variety of CPT codes used to reflect a CBC depending on the components used and the type of laboratory equipment involved. Using "CBC" as search criteria, we selected two LMRPs from the LMRP Web site (www.lmrp.net). There were 137 responses to this query, showing all the Intermediary and Carrier specific policies on file. The FI policy from Blue Cross and Blue Shield of Nebraska for hospitals, rural health clinics, and skilled nursing facilities contained no ICD-9-CM codes, but instead had six points describing indications and limitations of coverage. In this location, a software program is unlikely to help. The policy has a non-covered diagnosis code included (V82.9), which will result in a denial since it represents screening for a patient without signs, symptoms, an established diagnosis or prior abnormal test results.

We selected a second LMRP, a Part B LMRP administered by a Medicare carrier. Although a number of ICD-9-CM codes were provided as examples and could be used by a software vendor in a table returning information about meeting medical necessity criteria, the policy warns physicians that the list is not complete. At the beginning of the list of codes, the policy states that appropriate ICD-9-CM diagnoses, which "would underly the need for blood counts are far too extensive to be specifically listed."

Through the process of negotiated rulemaking, CMS has developed a national coverage policy for CBCs that will replace the myriad of LMRPs that providers currently have to search. The policies for laboratory testing coverage were published in the *Federal Register* and become effective November 25, 2002. Rather than listing the ICD-9-CM codes that would qualify the test for Medicare coverage, this policy is exclusionary. Any code not listed in the "excluded" list would be considered a valid reason for the test that supports medical necessity.

Don't Overlook Risks

The risk of reliance on screening software has some pitfalls that should be recognized before investment.

When the software to screen for medical necessity is used **prior to the service**:

- ABNs may be issued by the hospital when the service does not appear to be medically necessary, though the documentation in the record kept by the ordering physician supports coverage. Medicare beneficiaries may end up believing they must pay out of pocket for services that should be covered when a claim is filed. Also, it is possible that a covered diagnosis code may be assigned by the hospital coding staff based on information confirmed by a physician following the test results, when prior to the test, the clinician did not have enough information to report a diagnosis on the covered list. Medicare would pay for the service claimed and there would be no need to bill the patient, even though the patient was told up front that Medicare might not pay for the service
- when the software rejects the service as not medically necessary, the patient has to decide whether to pay for the test themselves or ask the provider to submit a claim for the purpose of getting a denial. Faced with these choices, patients may elect not to get a service their physician believes is needed. This situation can be complicated by the fact that when this occurs in a hospital, the physician is usually not available to speak with the patient and explain why the service was ordered. If the hospital indicates that it will go back to the physician for a "better" diagnosis, questions may be raised about the ethics of the coding process
- valuable time and resources are wasted selecting an "acceptable" diagnosis from the physician to progress with the service rejected by the software screening, even though the diagnosis provided would be appropriate and necessary for the condition, despite not being listed in an LMRP table

When the software is used on the back end of the process **before a claim is filed**:

- some providers using screening software might elect not to file a claim for a questionable or non-covered service and will write off the costs rather than submit a claim to the FI for the denial. If this is routine, there are instances where hospitals are losing dollars that they deserve and not taking advantage of the appeal process to affect coverage changes. They are also increasing the risk of providing inappropriate incentives for patient services by waiving patient coinsurance and deductibles and providing free care. For questionable services involving medical necessity, a claim must be filed to determine coverage requirements for the beneficiary. According to the Medicare Hospital Manual, Pub. 10, Section 430, these are the only circumstances where a provider should not submit a claim to Medicare:

  - the patient is not enrolled under Part B
  - it is obvious that only noncovered services have been rendered
  - payment was made in full by the National Institutes of Health Grant, Public Health Service, VA, or other governmental entity, or liability insurance
  - the period was covered in full by workers' compensation (including Beneficiary Liability), automobile medical, no-fault insurance, or in the situations described in ßß471E and 472E for an employer group health plan or large group health plan when you know that the individual has already met his deductible

- the "back door" approach assures that patients get the services the physician ordered without delay or questions, but increases compliance risks by encouraging the search for a "payable code." This can also cause the hospital to lose money by providing services that will be denied because they are not covered, and then cannot be billed to the patient because no ABN was completed at the time of service
- when a service is rejected with the code provided, the hospital may try to find a covered code using inappropriate methods such as assumptive coding, creation of leading inquiries to physicians, or using a source document for a code not appropriate for that encounter (such as documentation from a previous encounter). All of these practices are ethically questionable and increase the likelihood of false claims allegations against the hospital. Software tools should never be used as a reason to change or manipulate a patient's diagnosis for claims reporting without full knowledge and consent of the physician and assurance that clinical documentation supports the actual condition reported

What Is the Best Course?

The solution is easy to explain, but often difficult to carry out. Here are some tips:

- **Report the patient's actual condition** that reflects the reason for the test. If a hospital allows ordering physicians to submit the diagnosis codes rather than the narrative description of the reason for service, there is a risk that the code is not fully accurate when compared to the source document. Further, the narrative description enables the technician carrying out to understand the indications for the service and not have to translate the numeric code back to clinical information

- **Use a requisition form** that documents the reason for the service and enforce its use. Then, a coding professional specifically trained in coding conventions and reimbursement requirements can translate the information into ICD-9-CM codes used on the claim form.
- **Make sure** clinical documentation forms or formats **prompt** the users to fully document medical necessity for services ordered
- When ABNs are required, they are best **administered by the ordering physician** so that the patient is fully informed of the implications of payment or declining the service. This is much harder to accomplish at the hospital. Software assistance is most useful at this stage to educate physicians concerning Medicare coverage requirements and policies. For complete information about giving Medicare beneficiaries appropriate notification go to www.hcfa.gov/medicare/BNI
- Audit claims with medical necessity denials and **look for patterns** by actual service or by ordering physician. When trends are identified, targeted education can help improve documentation or communication of the reason for services to minimize denials and rejections for covered services. This education can ensure that non-covered services are identified in time to get the required notices given and allow the patient to make a fully informed choice
- **Use software as a tool** for managing coverage requirements and providing readily available education. Avoid reliance on any product that suggests codes when the conditions cannot be fully supported in documentation. Also, confirm that the product is using the correct set of guidelines. For hospitals, those are the policies that apply to institutions submitting claims to FIs. There are currently differences by locality and also between FIs and carriers for the same service, so make sure the tool you are using applies the correct set of guidelines to the reported services
- **Ask** the software vendor to illustrate how the software will help your facility manage those services where discrete code sets are not available or all-inclusive and the policy relies on text descriptions rather than ICD-9-CM code lists
- **Be confident** that when accurate clinical data is translated into the appropriate clinical codes the correct coverage decision will result with or without software assistance. When it doesn't, be sure to exercise the right to appeal

Medical necessity checking software can be a useful tool, but educated and ethical coding practices should form the cornerstone of the healthcare billing process.

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